Creative Support Limited

# Creative Support - Stockport Extra Care Services

## Inspection report

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14 September 2017

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| Is the service safe? | Good |
| Is the service effective? | Good |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Good |

# Summary of findings

## Overall summary

Creative Support – Stockport Extra Care Services provide care and support to people living in their own homes based within seven extra care housing schemes. The seven schemes were run as four projects/schemes dependent on their location. The four locations were Edgeley, Marple, Reddish and Heald Green areas of Stockport. The registered office for the service is located at Spey House in Reddish. At the time of our inspection the service was providing support to 130 people across the seven schemes.

This inspection took place on 12, 13 and 14 September 2017 and was announced.

At our comprehensive inspection of the service carried out in July 2016 we identified five breaches of three of the regulations of the Health and Social Care Act 2008 (Regulated Activities) 2014. These were in relation to; safe management of medicines; taking actions to mitigate potential risks; ensuring the competence of staff; record keeping and effective systems to monitor the safety and quality of the service. We also made one recommendation, which was in relation to ensuring all members of staff receive regular supervision. The provider was informed of the actions required in order for the service to become compliant with the identified breaches of regulations.

We last inspected the service on 13 and 14 September 2016 when an unannounced focused inspection took place. At that inspection, the team inspected the service against three of the five questions we ask about services: is the service safe, effective and well-led. Although improvements had been made in some areas, and were underway in others, we found continued breaches of these regulations. Again, the provider was informed of the actions required in order for the service to become compliant with the relevant regulations. The provider sent the Care Quality Commission an action plan informing of how they intended to become compliant with the breaches of regulations identified.

During this inspection of the service we found that all previous breaches of Regulations had been satisfactorily addressed.

At the time of our inspection the registered manager of the service had recently resigned. The Care Quality Commission had received the appropriate documentation from the registered manager with details of their resignation. A new manager had been identified and, at the time of the inspection, was waiting the return of relevant documentation from the Disclosure and Barring Service (DBS) prior to sending their application for registration to the Care Quality Commission. 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.

Within the registered managers resignation documentation it was stated that they had concerns about their lack of support from line management and issues relating to their management of the staff team. During the inspection we spoke in depth with the service director about the concerns raised and evidence was supplied

to demonstrate the support offered and provided to the registered manager during their employment with the service.

People told us that Stockport Extra Care provided them with safe and appropriate care to meet their identified needs.

We saw that all staff had been trained in keeping people safe and when we spoke with staff they told us they knew what to do should they witness or suspect poor practice or that abuse of any kind had occurred.

At the time of the inspection we found medicines to be safely managed with regular management overview of staff practice taking place.

People were supported to access health and social care professionals when required.

Staff were receiving training appropriate to the jobs they are employed to do.

People we spoke with were confident about raising complaints and confirmed that any complaint raised was dealt with in a timely manner.

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

## 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.

People received their medicines as prescribed by their doctor.

There was a robust system in place for the recruitment of staff.

Where risks were identified, appropriate assessments had been carried out.

### Is the service effective?

Good

The service was effective.

Staff had received appropriate training and supervision to support them in their job roles.

People were supported to access external health and social care professionals.

Staff were able to explain about the principles of the Mental Capacity Act 2005.

### Is the service caring?

Good

The service was caring.

People were supported by staff they got on well with, however some people preferred their support from regular staff rather than agency staff.

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

Staff respected people's privacy and dignity at all times.

### Is the service responsive?

Good

The service was responsive.

Care plans contained relevant details of people's support needs and preferences and had been reviewed on a regular basis.

People told us they were confident to raise a complaint and, where they had done this, a satisfactory and timely response had been received.

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

## Is the service well-led?

Good

The service was well-led.

There were processes in place to monitor the quality and safety of the service.

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

Prompt action had been taken by the provider in relation to our feedback and findings to make improvements to the service.

# Creative Support - Stockport Extra Care Services

**Detailed findings**

## Background to this inspection

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

We undertook an announced comprehensive inspection of Creative Support – Stockport Extra Care on 12, 13 and 14 September 2017. This inspection was brought forward in response to concerns we had received following the resignation of the registered manager of the service at the end of July 2017. These concerns related to lack of line management support and issues relating to their management of the staff team. The inspection team consisted of one adult social care inspector.

Prior to the inspection taking place we reviewed all the information we held about the service. This included notifications of serious injury, safeguarding and other significant events the provider is required to tell us about. Also, before the inspection took place, the provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We reviewed the PIR prior to carrying out the inspection. We also contacted the adult social care quality team at Stockport Council and Healthwatch Stockport. Healthwatch Stockport is an independent consumer champion for health and social care. We received information from the adult social care quality team that informed us the service had some initial 'glitches' in service delivery but had improved over time and that "staff are very quick to come back re: queries and referrals." Such information helped us to plan our inspection visit.

As well as looking at records held at the registered location of the agency, we also visited two of the seven

buildings (schemes) where the service provided support to people. We reviewed medicines management at both schemes we visited and spoke with five staff. This included the service director, a quality practitioner, a senior team leader and two care staff. We also spoke with three people who used the service and a regular visiting relative. We reviewed four care files, records of care provided and seven staff personnel files. We looked at other documentation relating to the running of the service such as records of audits and records of accidents and incidents.

Good

# Is the service safe?

## Our findings

At our inspection on 13 and 18 July 2016 we identified concerns in relation to the safe management of medicines. This resulted in a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our next inspection on 13 and 14 September 2016 we identified continuing concerns in relation to the safe management of medicines. We found two medicines errors that we asked the service director to report as safeguarding issues to the local authority. On the medication administration records (MARs) we saw that a significant number of signatures were missing to confirm that people had been administered their medicines. We also found that although medicine audits were thorough and staff who made errors had been given further training and supervision to help ensure they were competent, we did find in one scheme a 'spot check' audit that did not identify that an important medicines had not been administered.

These concerns in relation to the safe management of medicines were an on-going breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that medicines were kept safely as people were given a lockable storage box in their room, with the carer keeping the key if risks had been identified in relation to the open storage of medicines. During our visit to the schemes we asked two people who required support with their medicines if we could check their medicines stock against the MAR. We found both MARs to have been correctly signed by the care staff and medicines corresponded to those identified on the MAR. We also checked six 'archived' MAR's and found all had been signed with action taken when a missing signature had been found during a medicines audit.

People who used the service, who we spoke with, told us they received their medicines as prescribed by the doctor. One person told us, "The staff are very good; they make sure they give me my tablets when I should have them". Another person said, "Although I always get my medicines they [staff] can sometimes be late, especially on a Sunday." We later discussed this matter with the service director who confirmed action had been taken with the staff team to address the concern raised.

We looked at the training matrix provided by the service director which indicated that care staff had received appropriate medication training and this was confirmed by the staff we spoke with. We also saw that any staff that made errors had been given further training and supervision to help make sure they remained competent when managing medicines. We found that regular 'spot check' audits of medicines were being conducted, with relevant actions being taken where required.

The service's medicine policy gave clear guidance on how to handle medicines safely and all staff had access to this.

These findings demonstrated that the breach of regulation 12(1) found at the last inspection had now been satisfactorily addressed.

At our inspection on 13 and 18 July 2016 we identified that the assessment of risk in relation to the care people were receiving was variable. We saw instances where potential risks had not been identified in the risk assessments. These findings resulted in a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection on 13 and 14 September 2016 we identified concerns in relation to assessing and mitigating risks for people using the service. We found a lack of risk assessments being carried out where people may have been at risk of developing pressure sores or having falls. Also, we found that one person requiring the use of a standing hoist did not have a moving and handling risk assessment in place. The lack of a risk assessment in such circumstances meant the provider was unable to demonstrate potential risks and measures to reduce risk had been adequately considered.

This was a continued breach of Regulation 12(1) of the Health and Social Care Act (Regulated Activities) Regulations 2014 in relation to assessing and mitigating risks.

During this inspection we looked at four care plans and related documentation. We saw that a detailed risk assessment was in place for a person with a diagnosis of epilepsy, with very clear directions and guidance for staff to follow should the person have a seizure. This assessment had been reviewed by the quality practitioner with the service user in August 2017. Other risk assessments in place included; household safety and falls prevention, potential risk of pressure sores, monitoring tissue viability and moving and handling.

We spoke with the person who had a diagnosis of epilepsy to obtain their views about the knowledge and understanding the staff had regarding this medical issue. They told us that they were confident that the staff would manage the situation safely should they have a seizure and knew there were clear directions in their care plan/risk assessment of the action for staff to take should a seizure occur. We also saw that there was a letter from the person's doctor confirming what medication could be administered orally in the case of a seizure.

People at risk of developing pressure sores had been identified and logs were in place with measures to be taken to reduce potential risks, such as input from district nurses, pressure relief or use of specialist equipment such as pressure relieving mattresses. Such information was transferred to individual's risk assessments in some cases and we saw evidence that these assessments were reviewed and updated when there was a change in a person's circumstances. To help staff understand how pressure areas develop and what to look for, photographs of the different types of pressure areas/sores people could suffer with had been placed in an information file which was accessible to all staff.

The training matrix indicated that some staff had completed training in relation to pressure care and that others still needed to complete this training. In our discussions with the service director it was confirmed that this training was on-going and all staff would complete this training within the next three months. One of the care files were reviewed was for someone at risk of developing pressure sores. Adequate information was included in the risk assessment and care plan to help staff meet this person's needs appropriately.

These findings demonstrated that the breach of regulation 12(1) found at the last inspection had now been satisfactorily addressed.

The service director informed us Stockport Extra Care was commissioned to provide support to people between 07:00 am and 10:30 pm. outside these hours some people had night calls commissioned from a Stockport Council service. People also had access to an emergency call service and staff carried out welfare calls for people living at the schemes on a daily basis.

The service director told us there were 21 full-time equivalent vacancies for support workers across the service. They informed us shifts were first offered to regular, permanent staff, before being put to the services bank staff team. If shifts were not able to be covered with regular or bank staff they were then put out to agency staff. We looked at rotas, which showed shifts had been covered and also confirmed there was regular use of agency and bank staff. The service director told us recruitment of permanent staff was still very challenging. We could see that both the provider and service director was carrying out an on-going recruitment campaign and were continually trying to attract new staff.

To make sure staff attended all calls, a shift allocation sheet was provided to inform each member of the staff team the calls they had to complete. If, for any reason, a call had been missed, appropriate action would be taken by the registered manager/service director including seeking advice from a health professional in relation to missed medicines. People we spoke with who used the service told us that the regular staff had never missed a call, they could sometimes be late, but calls had not been missed. One person said, "The service is very, very good. You have to accept sometimes calls may be a bit late if the staff are dealing with an issue with someone else."

People we spoke with told us they felt staff helped keep them safe. One person told us; "The staff are lovely. They help me with the things I need help with and they are reliable." Another person said; "Of course I feel safe. I'm in my own home and the staff respect my home. The staff always makes sure I'm okay and remind me to press my call button if I need anything or should have a fall. That makes me feel safe." Staff confirmed they had received training in safeguarding and were able to explain potential signs of abuse or neglect they would look out for and report to their manager. They told us they were comfortable in the knowledge that they could approach the service director or team leaders about safeguarding concerns and that their concerns would be acted upon.

The service director provided us with details of the records relating to safeguarding concerns reported to the local authority and any actions taken in relation to those concerns. Prior to the inspection we received information from the Adult Social Care Quality Team based at Stockport Council. This information detailed some concerns about safeguarding matters currently under investigation and some of the agreed actions to be undertaken by the provider. The Quality Team will be meeting with the provider to further discuss matters in the near future.

We looked at records of staff recruitment and saw evidence that processes were in place to minimise the risk of unsuitable people being employed. We saw required checks had been completed prior to a new member of staff starting work, such as obtaining references from former employers and applying and receiving a satisfactory disclosure and barring service (DBS) check. DBS checks tell an employer whether the applicant has a police record or is barred from working with vulnerable people. Applicants were also required to complete a health declaration and to attend an interview.

Staff we spoke with were aware of the action and procedure to follow in the event of an accident such as someone sustaining a fall. We saw copies of incident forms were kept in individuals' care files and any actions required to reduce potential risk had been discussed and recorded by a member of the senior management team.

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

Various housing associations owned the different premises and were responsible for the maintenance and upkeep of the premises and many of the safety checks required. We saw that the service director had checked to see that required servicing had been carried out as part of their quality auditing and monitoring of the service.

Good

# Is the service effective?

## Our findings

At our inspection on 13 and 18 July 2016 the provider was unable to demonstrate that all agency staff had received a full and adequate induction to the service. This resulted in a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection on 13 and 14 September 2016 the provider had made some improvements to the process for inducting agency staff but we still found that agency staff not having received an appropriate induction since our inspection conducted in July 2016. This resulted in a continued breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of this inspection we asked the service director to explain how agency staff were being inducted when first starting work for the service. We saw that an induction process was in place, comprising of a check list of essential information, some gathered prior to starting work and some that is completed throughout the working shift. We saw evidence that all existing agency staff had completed the new induction process and had access to an agency induction file containing key information on the service and how to access further support as required.

An agency information leaflet had been developed that was sent to all agencies used by the service to distribute to agency staff before they attend the service, especially for the first time. Agency staff are then required to read and sign to confirm they have understood the information in the leaflet, with a copy being placed on their file.

The service director informed us that an agency data base had been set up to log all the training completed by agency staff, the date of their induction and dates of supervisions and medicines observations.

All care staff, including agency workers are provided with a plastic wallet on each shift containing their allocation list, emergency contact numbers, blank care records, spare disposable gloves and a brief overview of actions to be taken should the fire alarm activate.

Those agency staff working for the service on a regular basis had been placed on a 'rolling purchase order'. This meant that managers could book these agency staff directly on the rotas to enable continuity of support for the people using the service.

These findings demonstrated that the breach of Regulation 18(2) of the Health and Social Care Act (Regulated Activities) Regulations 2014 had been satisfactorily addressed.

Although the provider had continued to use agency staff, they were also continuing to make concerted efforts to recruit permanent staff. At the time of this inspection the service had the equivalent of 21 full time vacancies across the seven schemes. The service director provided us with evidence of the recruitment initiatives that had been developed during 2016-2017 and the recruitment drives that had taken place. We saw that events had been held at various places throughout the borough including railway stations,

shopping centres, open days, advertisement on local buses and jobs fairs.

We were provided with a training matrix of all training permanent staff had undertaken, which included mandatory induction training, which covered areas including medicines, first aid, moving and handling, food and nutrition, safeguarding, person centred approaches and health and safety. Staff we spoke with told us they received all the training they needed to enable them to undertaken their role effectively, and told us the training was of a good standard. Records showed that staff had completed training in areas including safeguarding, manual and people handling, medicines and first aid. Staff also had the opportunity to participate in training that particularly interested them in addition to the standard training.

Staff told us they received regular supervision sessions with their line manager and that they found this a good way of receiving some individual support. Records seen demonstrated that supervisions had been conducted along with annual appraisals. We saw evidence that 'Themed supervisions' in relation to topics such as safeguarding and the Mental Capacity Act had also been carried out. This type of supervision would help the service director to make sure that staff were competent and received appropriate support in these areas of practice.

Regular checks of staff competence and practice were being carried out and line managers provided feedback with the staff including any areas for potential improvement. Line managers also carried out 'observational of practice' with staff, which included a competency check when administering medicines to people using the service. Where these checks highlighted shortfalls, we saw that 'situational supervision' had taken place, for example, if a medicine error had occurred. Following this the staff member would complete a 'reflection account' of why an error had occurred and what they needed to do to ensure no repeat or further errors took place. This was then followed by three competency checks to make sure lessons had been learnt. This process was confirmed by one member of staff we spoke with who had recently been supported to complete a reflection account. Such action would help the manager to make sure that staff remained competent and received support in these important areas of their job role.

Care records indicated that, where required, people received support from community health professionals such as doctors and district nurses. Staff told us they would ring for a doctor's visit or other professional if they had concerns in relation to someone's health, and people and a relative we spoke with confirmed this was the case.

All of the people we asked told us staff always stayed the correct amount of time on calls and completed all tasks that were expected. One person told us, "You can rely on the staff to do the jobs I need doing and, if there is time, we sit and have a chat." Those staff we spoke with told us they thought enough time was planned to carry out each call, but if circumstances changed for a person and more time was needed, the management team responded to this and informed the person's social worker. One member of staff told us, "Our management team take a 'hands on' approach and if we are short staffed or need help they [management] will also do some calls to help out."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

The service director told us the service was not depriving anyone of their liberty and said it was unlikely the service would be able to meet the needs of a person who required restrictive practices amounting to a deprivation of liberty. The service director was clear about their role in identifying which people may lack capacity to take certain decisions, and then making sure any best interests decisions taken were documented and put in place. Staff received training in the Mental Capacity Act as part of their induction to the service and some staff had completed further training in this subject. The staff we spoke with were able to demonstrate a reasonable understanding of issues relating to capacity, consent and best interests. Staff records demonstrated that MCA themed supervisions had been carried out with some staff, and further sessions had been arranged with the remaining staff.

People who were able to, had signed consent forms in relation to areas of support including access to records, support with finances, support with medicines and key holding. Staff were able to demonstrate an understanding of issues relating to capacity and consent and people using the service, who we spoke with, told us that staff always sought their consent before providing care. One person said, "The staff never do anything without asking me first, like, is it okay if I go in your bedroom to put some clothes away?"

Good

# Is the service caring?

## Our findings

People provided with a service were supported by both permanent and agency staff. Those people we spoke with told us they preferred to receive their support from regular staff or regular agency staff rather that agency staff that come as a 'one off'. One person told us, "I have no problem with the agency staff, but some that only come for one day don't know me and I don't always feel as comfortable as I do with the regular staff. Some of the agency staff are better than others at doing the job." One relative told us they had a very good relationship with all the staff and management at the service and that most staff did a really good job at looking after their relative.

Other comments received included; "The carers that come to me are very, very good. They know what they are doing and [staff member name] is wonderful, nothing is too much trouble." Staffing rotas seen indicated that management took a consistent approach when covering vacant shifts. We saw that many of these shifts had been allocated for cover by permanent staff before being offered to agency staff.

Each person we spoke with told us the staff supporting them were respectful and caring in their approach. They also said that staff respected their privacy and dignity at all times. Whilst speaking with one person who used the service, a member of staff knocked on the door, called out their name and quietly entered. When they saw a conversation was taking place, they apologised and said they would call again in ten minutes if that was okay. This demonstrated that the member of staff had a caring, considerate and respectful approach when providing support to people. All the staff we spoke with were able to tell us about the people using the service and their individual likes, dislikes and daily lifestyles. This indicated that the staff team knew the people well.

People told us that staff allowed them to maintain their independence wherever and whenever possible. One person said, "I can fill the kettle and staff let me do that, but I can't pour the boiling water into the cup so the staff do that for me." Another person told us, "I do as much as possible for myself with the carers doing the things I need support with. I know I have a care plan and we do talk about it sometimes, including the help I need." We saw evidence of regular care plan reviews where feedback had been sought from individuals or their designated representative. This was usually a member of their family who was consulted with as they know the person using the service the best.

Information on people's communication support needs were detailed in their care plans, which would help staff communicate effectively with them. Where people have limited verbal communication staff told us they would look for other ways the person might be trying to communicate with them, for example, body posture, facial or hand gestures. We were provided with a copy of the latest newsletter produced for the service, which had details, photos of events that had taken place and had news articles and updates that would help keep people informed about developments within the service. It also contained the outcome of the Annual Service User Questionnaires carried out in May 2017. It stated that all of the feedback received would be used to help shape the service and future support provided.

Good

# Is the service responsive?

## Our findings

People and relatives we spoke with told us care staff arrived on time to provide support and would stay longer if there was a particular need to do so. One person told us: "The times I need support are in my care plan and most of the carers turn up on time. If they are busy, sometimes they are a bit late but they do always apologise." Another person said; "I need the carers to turn up on time because I like to take my medicine in a certain way at a certain time. This mostly happens, but at weekends especially, the carers or agency staff can be late. I have complained about this and I do get a response from head office."

The care plans seen were fully completed and contained relevant details and information for care staff to support the person appropriately whilst focussing on the desired outcome for the person. The development of each person's care plan considered a range of support needs including nutrition/hydration, maintaining independence/daily living skills, mobility, mental health, continence and activities. Staff we spoke with told us they thought the care plans contained sufficient information to allow them to understand how best to meet people's identified needs.

Regular staff we spoke with told us they were provided with time to read and review people's care plans before providing support. People who used the service, who we asked told us they thought regular staff knew their needs because details were contained in their care plans. One person however said they thought agency staff did not always read the care plans because they sometimes had to tell them what they needed to do. "It is usually the agency staff that come as a 'one off' doesn't always know what they should be doing." We saw that at the start of each shift staff were provided with 'allocation sheets' which contained a brief summary of the support people required, and this would help ensure staff were aware of people's support needs.

Details in care plans highlighted that regular reviews had been carried out and any changes to the care plans had been clearly recorded. For example, if a person had been in hospital, a review took place on their return home to ensure information was updated to reflect any changes needed to their support needs. People told us that staff were flexible in their approach when meeting their needs and would often make arrangements to call back, for example, if the person had a visitor. Another person told us how staff would often pop in between calls and offer to make them a cup of tea or just to check on them.

Care plans detailed people's preferences in relation to the support they received. For example, one person's care plan documented that they wanted female carers only to provide their support. Care records contained one page profiles that included information about people's life histories, likes and dislikes, past occupations and general interests. Such information helped staff get to know the people they were supporting and would also provide some potential topics for discussion. Regular staff we spoke with were able to tell us about the people whose care plans we had reviewed and the information shared matched the details in the plans.

Two people and one relative we spoke with told us they had raised complaints in the past. All said their complaint(s) was dealt with effectively and they also received a timely response. The service director

provided us with details of the complaints received across the seven schemes since January 2017. There had been a total of 23, all of which had been investigated, with outcomes detailing the action(s) taken and whether the complainant was satisfied with the response. All people using the service we spoke with told us they would feel confident to raise a complaint with the Registered Manager or a member of staff if they had any concerns.

We also saw that the service had received a number of compliments including relatives' thanks for the care their relative is receiving and the support provided by "wonderful carers."

The service director told us Stockport Extra Care staff were able to support some activities within each scheme. Rolling rotas of activities were in place, which included events such as weekly chippy nights, afternoon tea, bacon butties and tasty evening meals. One popular activity in most schemes was weekly Bingo sessions. Information about activities available were advertised in the Stockport Extra Care Newsletter. People we spoke with talked positively about the activities on offer. One person said, "We have a nice meal downstairs (communal area) on a Thursday evening and people can have a chat and socialise." Such events helped to provide people with opportunities to have their social needs met and staff encouraged people to attend in order to minimise the risk of social isolation for some people.

People using the service had the opportunity to attend tenants meetings which were held by the different housing associations at the different schemes. People were supported by a member of staff from Stockport Extra Care who also attended the meetings to help make sure effective communication was maintained and to address any issues arising in relation to the support service provided.

Good

# Is the service well-led?

## Our findings

The service is required under the conditions of their registration with the Care Quality Commission to have a registered manager. Although a manager was registered with the Care Quality Commission, the person in this post had recently left their employment with the service. At the time of the inspection the service director was managing the service and had also sent in their application to the Care Quality Commission to become registered as the manager of the service.

Within the registered managers resignation documentation it was stated that they had concerns about their lack of support from line management and issues relating to their management of the staff team. During the inspection we spoke in depth with the service director about the concerns raised and evidence was supplied to demonstrate the support offered and provided to the registered manager during their employment with the service.

At our inspection on 13 and 18 July 2016 we found the systems and processes in place to monitor and improve the safety and quality of the service had not been effective. For example, medicine errors, discrepancies and concerns had not been consistently identified and addressed. This resulted in a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection on 13 and 14 September 2016 the provider had made some improvements to the way in which the safety and quality of service was monitored but shortfalls were still found during this inspection which resulted in an on-going breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our last inspection of the service the internal quality assurance team from the organisation had been providing support across the schemes to further develop and maintain effective quality monitoring of the service.

During this inspection we looked at how the provider monitored the quality and safety of the service being provided. We found that regular 'spot checks' of medicines practice had been carried out which identified any shortfalls in the management of medicines by care staff. Where shortfalls had been found we saw that appropriate action had been taken and staff had carried out a 'reflective account' followed by regular competency checks.

We were provided with a copy of the last internal quality audit for one of the schemes which had been conducted on 22 December 2016 by a senior quality practitioner and a quality and compliance practitioner employed by the organisation. The service director told us that following receipt of the report action had been taken to address any areas of service delivery where shortfalls had been identified.

At the time of the inspection the service director was responsible for carrying out audits at each of the schemes on a bi-monthly basis. These audits covered aspects of service provision including health and safety, staff, supervisions, accidents and incidents and care plans. In our discussion with the service director

we were informed that a full and complete audit was due to take place of each of the seven schemes during October 2017. The service director confirmed they would send the Care Quality Commission the results from the findings of those audits.

We were provided with a copy of the latest Incident Log for the Smithy Croft scheme. The log contained details of the service user, staff members present, summary of incident, action taken and comments and learning. There had been a total of 23 incidents recorded over a period between 7 July and 21 August 2017. All incidents had been reported within 24 hours to the service director with full details of the actions taken. These logs were used by the team leaders to help monitor any trends occurring in accidents and incidents.

We were provided with a copy of the latest Safeguarding Incident report for across the seven schemes. There were a total of 18 safeguarding incidents recorded between 27 January and 4 September 2017. We cross referenced these reports to the notifications the Care Quality Commission had received and found that they corresponded.

These findings demonstrated that the breach of Regulation (17)(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been satisfactorily addressed.

At our inspection on 13 and 18 July 2016 we found that the records staff kept of the care and support they provided to people were not always fully and accurately completed. This resulted in a breach of Regulation 17(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection on 13 and 14 September 2016 we found that staff were still not consistently recording information relating to important aspects of people's care, for example, poor recording of records relating to food and fluid intake. These findings resulted in a continued breach of Regulation 17(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that where required, records for food and fluid intake had been recorded and were up to date. Records of the repositioning of two people had been completed consistently. Daily logs on the wellbeing of each person had been completed at each shift with some staff recording more detail than others and this was discussed with the service director.

These findings demonstrated that the breach of Regulation 17(1) of the Health and Social Care Act (Regulated Activities) Regulations 2014 had been satisfactorily addressed.

Staff we spoke with during the inspection told us they felt they received very little support from the previous registered manager of the service but were now receiving positive and constructive support from the service director. Comments we received from people who used the service included; "I think the service is managed very well, [name of staff] is very helpful as are [names of carers]", "Overall I think the service is well managed and meets my needs" and "Lovely staff, whether managers or not, I like the service." Other comments about the management of the service included; "The last registered manager changed so many things and the way we do things that staff didn't know where they were up to" and "I think we have very good, professional support from the service director, who is going to be the registered manager."

We saw evidence of support and management directives being provided by the Chief Executive of the organisation to all senior management team members, including site based senior staff. The quality improvement directive for the period 12 June to 23 July 2017 covered the following areas, medication, specific medication plans, medication observations, staff supervisions, staff training, client files, complex health needs and use of agency staff. We found that appropriate action had been taken by the service

director and senior staff of the service to address the matters raised in the directive.

Staff we spoke with told us that staff meetings were held on a regular basis and we were provided with minutes from the meeting held on 19 July 2017, with the next planned meeting for the Smithy Croft scheme taking place on 15 September 2017. The planned agenda items included: Service users, safeguarding/code red, whistleblowing, medication, pressure care, good nutrition and hydration, health and safety, Creative Support no lifting policy, fobs and work mobile phones, fire procedure, complaints, compliments, incidents and lessons learned, record keeping, MCA and any other business. The date of next planned meeting was 12 October 2017.

As well as regular staff meetings taking place we saw evidence that there had been reflection of incidents where points for learning and improvement had been discussed with individuals and the staff team. This indicated the service was learning from experience to make the service safer and more effective. Records we looked at showed there was regular contact between Stockport Extra Care staff and staff working for the housing association who managed the buildings. This included regular meetings as well as regular contact about specific housing related issues. This would help ensure a well-coordinated service was provided to people.

We also saw that staff were kept up to date with changes taking place within the service / organisation by way of regular updates / memos. We saw a memo from 26 July 2017 informing the staff team of the resignation of the registered manager and the planned management support for the interim period until a new registered manager was in post.

There was a range of policies and procedures for staff to access and follow and evidence was available to demonstrate that the service was working in partnership with other health care organisations to make sure that current good practice was being followed that enabled people to receive a good quality service and remain safe whilst living in the Stockport Extra Care support schemes. These health care organisations included doctors, district nurses, speech and language therapists, dieticians, commissioners of services and social service departments.

Before the inspection, we checked the records were held about the service. We found that the service had notified the Care Quality Commission (CQC) of events such as safeguarding's, accidents and incidents. This meant we were able to see if appropriate action had been taken by the service to make sure people were kept safe.

It is a requirement that the latest CQC inspection ratings are displayed. The provider had displayed the CQC rating on a notice board near the main entrance to the offices.