

London Borough of Redbridge

Oakfield Lodge

Inspection report




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Date of inspection visit:
15 August 2018
16 August 2018
04 October 2018

Date of publication:
26 November 2018

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?	Good 
Is the service well-led?	Requires Improvement 

Summary of findings

Overall summary

We completed an inspection of Oakfield Lodge on 15 and 16 August and 4 October 2018. The inspection was announced. We had previously inspected the service on 24 February 2016 and rated the service as Good.

Oakfield Lodge is registered to provide care and support to people living in specialist 'extra care' housing in London Borough of Redbridge. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is bought or rented, and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service. This type of housing allows people who need the reassurance of 24-hour care and support to continue to live independently in their own home for as long as possible. The Oakfield Lodge scheme has self-contained flats with access to communal areas and social activities. Some tenants of the scheme were independent and did not receive personal care or support from the service. There were 30 people within the Oakfield Lodge scheme who received personal care from the service.

There was a registered manager in place. 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.

Risk assessments were in place however, they lacked detail regarding plans to mitigate risk. This did not adhere to the provider's policy on risk management. There were also no records of lessons being learned when things went wrong as the registered manager did not complete any analysis of incidents or accidents.

Staff did not receive training that was planned to take place and had not received refresher training in certain topics for over 3 years. There was a lack of robust governance procedures in place, including a lack of audits or quality assurance checks. The registered manager told us they completed no audits and were unaware of audits taken by the local authority which they should have known about.

People's privacy and dignity was only respected sometimes. Staff did not always knock before entering their properties and people's personal information was not always kept securely.

People's concerns and complaints were not always listened to. People told us they felt nothing happened following their complaints and we found the registered manager was not maintaining a log of complaints.

People were safeguarded from abuse through robust policies and procedures and staff's knowledge of what to do if they suspected abuse. There were enough staff working at the service to meet people's needs and there were responsible recruitment procedures were in place.

People's needs were assessed appropriately before they started using the service by social workers with

whom the service had close links with. Staff received supervision and appraisals to support them in their roles. People were supported to have a balanced diet and to eat healthily. Staff had systems in place to communicate effectively.

People were supported to access relevant health care services and the provider was compliant with their duties under the Mental Capacity Act 2005. People received personalised care that was responsive to their need and they told us they were treated with respect and that staff were caring. People and staff told us they were able to express their views through meetings and surveys.

Staff spoke positively about the management. The service had good links with the local community.

We identified breaches of three regulations relating to safe care and treatment, good governance and staffing. You can see what action we told the provider to take at the back of the full version of the report.

This is the first time the service has been rated Requires Improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always Safe.

Risk assessments were not personalised and risk management plans lacked information.

People were safeguarded from abuse.

There were sufficient staff to provide care and the provider recruited people responsibly.

There were no records of lessons being learned when things went wrong.

Requires Improvement ●

Is the service effective?

The service was not always Effective.

Staff did not receive regular and ongoing training. However, they communicated effectively and received supervision and appraisals.

People's needs were assessed appropriately, they were supported to have balanced diets and they were also supported to access health care services.

The provider was compliant with their duties under the Mental Capacity Act 2005.

Requires Improvement ●

Is the service caring?

The service was not always Caring.

People's privacy and dignity were not always respected by staff.

People and their relatives were involved in their care planning.

People were able to express their views.

Requires Improvement ●

Is the service responsive?

The service was Responsive.

Peoples concerns and complaints were not always listened to. The registered manager told us that no record of complaints was kept but they would begin to do so, and the service manager also gave us assurances.

People received personalised care that was responsive to their needs and their needs were assessed and reviewed regularly.

Good 

Is the service well-led?

The service was not always Well-Led.

There was a lack of checks and audits in place to monitor the quality of care at the service.

People and their relatives had positive opinions about management of the service.

People were able to be engaged and involved in the service.

The service had good links with the local community.

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Requires Improvement 

Oakfield Lodge

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.

This inspection took place on the 15 and 16 August and 4 October 2018 and was announced. We gave the provider 7 days' notice so as to ensure that members of the management team and staff were available to talk to as the service provides domiciliary care. The inspection was completed by one inspector.

Before the inspection we reviewed the information we already held about this service. This included details of its registration, previous inspection reports and notifications of serious incidents the provider had sent us. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We contacted the local authority with responsibility for commissioning care from the service to seek their views.

During the inspection we spoke with five people and five relatives. We spoke with three staff; the registered manager and two carers. We also spoke with one visiting health and social care professional. We observed how staff interacted with people. We looked at five care plans including medicine administration records. We examined staff recruitment, training and supervision records for six staff, as well as other records relating to how the service was run.

Is the service safe?

Our findings

Risks to people were assessed, however, we found risk management to be lacking in personalised detail and without guidance for staff to work with the risks. We looked at five people's care records and saw that each had a general risk assessment. The risk assessment used a low, medium and high measurement to indicate the risk in each section. The risk assessments we saw were all reviewed and signed by the registered manager. The registered manager told us they completed the risk assessments.

There was minimal detail about the risks within the risk assessments and there were no completed risk management plans for when a risk was indicated. Each risk assessment contained a section to provide a risk management plan and we saw only one that had anything written in this section. We saw notes of an individual's progress in the risk management section, rather than what actions to take to manage that person's risk. One staff member we spoke to told us they did not use the risk assessments.

We noted that there were body maps in one person's care plan indicating this person had sustained injury but no risk assessment review had been recorded. Whilst the review may have taken place and not been recorded as no change deemed necessary, This example highlights a possibility that subsequent injuries may have been prevented had the risk assessment and risk management been updated.

This lack of risk management meant that there was a potential for people's risks to be overlooked, thereby putting them at increased risk or harm. This increased risk could conceivably have severe implications for people's health and wellbeing.

Following our inspection the service manager for the provider wrote to us and informed us that risk assessments were undertaken in line with the local authority's risk management policy. We found that risk assessments were not undertaken in line with this policy as in some cases there was no risk management plan. The service manager said, "There is one generic risk assessment and a 'moving and handling assessment' that is completed by a qualified Occupational Therapist, when input from them is requested due to mobility and needs. The Moving and handling assessment is for when mechanical machinery such as hoists are in place for service users."

There was also no record of actions being taken or lessons learnt when things went wrong. The registered manager assumed responsibility for any such actions and whilst they were not recorded they assured us that they would always do what was necessary to safeguard people using the service. Incidents and accidents were recorded but only in a chronological list which was not used as a means to track patterns or provide insight into themes that might affect people using the service.

The registered manager told us that when accidents occurred to people they were recorded on this system as well as on body map documents that are placed in people's care records. We saw the body maps in people's records. These body maps indicated where injuries were but often provided no reason as to how they were sustained.

The provider hadn't taken steps to fully assess and mitigate risks to people's health and safety. Nor had they recorded any actions being taken or lessons being learned when things went wrong. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for Safe Care and Treatment.

People were safeguarded from abuse. Staff had received training about safeguarding and knew what to do if they suspected abuse. One staff member told us safeguarding meant, "Protecting vulnerable adults and everyone in your care." Records indicated all staff had received safeguarding training with four having received refresher safeguarding in the past two years. Safeguarding issues were recorded as an incident and reported to the social work team with whom the service had close links. The service also sent The Care Quality Commission (CQC) notifications of safeguarding concerns having first alerted the local authority safeguarding team. All staff told us they would report abuse to their manager.

There were sufficient numbers of staff to provide personal care. The registered manager and staff told us that agency staff were used when there was sickness and absence. Agency staff that were used to cover absence tended to be long term cover and staff and people knew who they were. Agency staff were trained appropriately for the role and had the right skills and knowledge to meet people's needs. We saw rotas that indicated short and long-term planning of staff working hours. The registered manager told us they were able to plan the staff according to the care hours deemed required for personal care by local authority social workers. The registered manager told us new staff were being recruited in Autumn 2018.

The provider recruited people responsibly. Various pre-employment checks were carried out on staff. All staff completed Disclosure Barring Service (DBS) checks prior to employment and these were updated at regular intervals. The DBS check supports employers by checking that people being employed to work in a social care setting are suitable to do so. They do this by checking their criminal record and any registers pertaining to individual's characters. Employment references, proof of identification and a record of previous employment were also sought. This meant the service employed staff who were suitable to work.

People were supported with their medicines. People told us they were happy with the support they received with their medicines. One person said, "Yes – when I need I can ask [staff]." However, we were concerned with the lack of refresher training staff received in medicine administration. All staff had received training to provide medication, although only two people had received refresher training in the last twelve months.

Some staff had not received refresher training in medicine administration since being trained some seven years previous. The registered manager was aware of this and had requested there be some form of competency refresher training hence two people being refreshed this year. The registered manager hoped all their staff would receive refresher training in the coming year though had not completed any training plan at the time of the inspection. Following the inspection the service manager also told us that refresher training is a, "Work in progress as due to the nature of the service only a limited number of staff can attend."

Staff were competency checked administering medicines through regular spot checks completed by management and administration staff. They checked whether people received the right medicines and they were being administered in the right way. Peoples medicines were recorded on Medicine Administration Record (MAR) charts kept in their care plans. We saw that these were completed correctly and signed for by staff. Medicines taken as and when needed were also recorded here.

People were protected from spread of infection through prevention and control. We observed staff wearing personal protective equipment such as gloves and aprons. One member of staff told us, "We always use gloves and aprons and change when do different service user. Put soiled stuff in yellow bags – use

disinfectant and gel on hands. Here is very nice and clean". People were provided with food from a kitchen which had received a five for food standards rating. This was the highest rating the food standards agency can give.

The service had a business continuity plan. This was a plan for if things went wrong. The plan stated what to do and who to contact in emergency.

Is the service effective?

Our findings

Staff were not always provided with training and refreshers to provide them with the skills to perform their roles. The service used a digital system that recorded the training staff had received. The registered manager was able to show us individual training profiles for each member of staff. Staff at the service told us they received sufficient training, one member of staff said, "We do [a lot] training online." Another staff member said, "I worked for [local authority] for a number of years. I am due to go on first aid course shortly." However people had mixed views on whether staff were skilled and experienced. One person told us, "Not so much." However; another said, "I think so."

We saw from records provided to us that there was a lack of training or refresher training provided and the registered manager lacked oversight of the service's training needs as they were unable to fully utilise their digital system. For example, we noted that individual training records stated no members of staff had received end of life training for three years. The same records showed only four people had received safeguarding refresher training in the past two years and that only two people had received any medicines training in the last five years. At least two people had not had any medicines training in the past seven years. No one had been recorded as receiving dementia training in the past two years. This lack of training meant that staff may be unable to provide the appropriate care within specific areas of their work, or they were unaware of current best practice, which would have a direct impact on the care people received.

We asked the registered manager about the lack of training and they told us that there were budgetary constraints and they were limited to what the local authority's learning and development team could procure. They also explained there were limited places as they needed to share training opportunities with their sister unit's employees. The registered manager was able to provide us with a training plan from 2017 to 2018, the training plan highlighted that all staff needed end of life training and medicines training, however as previously stated, records demonstrated staff had not received the training.

After the inspection the service manager wrote to us and informed us that a training needs analysis was completed annually and a matrix provided oversight of this analysis. They also told us that they were working in partnership with the local health trust which increases training opportunities.

The provider hadn't taken steps to ensure their staff had the knowledge and skills to fulfil their roles. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for Staffing.

We were not able to see any current induction records of staff as no new staff had been employed in the past seven years. The registered manager told us that all employees of the local authority have to complete a generic induction. They said if they were to employ someone they would ensure they received a local induction which they would then share with the human resources department. We were told this local induction would cover important information and training such as safeguarding, administering medicines, reading policies and procedures and shadowing existing staff in their role. They also explained as there had been no recruitment in seven years they had not needed to create any local induction policy, procedure or

document.

People's needs were assessed prior to accessing the service. The service was managed by the local authority and people using the service were assessed by social workers who work for the borough. These assessments were then shared with the service. The assessments we saw were sufficiently detailed to provide a picture of a person's needs, their risks and their capabilities.

The service used a digital system to record when people received supervisions and appraisals. The registered manager informed us that this was part of the local authority's drive to reduce the use of paper. The registered manager was able to show us that staff had received supervisions and appraisals. However; staff had mixed views about whether they received enough support. One staff member told us they received, "No supervision." They went on to say that on some shifts they would be asked, "have you got any problems?" Whilst another staff member said, "Yes. I know I can pop into the office and say [if I need support]." This showed that there were inconsistencies in the support available to staff.

People were supported to maintain a balanced diet. The service was an extra care scheme and as such people had their own properties with kitchens and could cook for themselves. The scheme also managed a kitchen and cafeteria where tenants of the scheme could receive breakfast, lunch and dinner at subsidised prices. Those who needed were supported at meal times to eat and drink, either in the cafeteria or in their homes. A relative told us, "Yes they bring the food to them and emulsify it for them." Whilst another relative told us, "Yes definitely. If it wasn't for them [person] wouldn't be alive today, [person] eats all their meals."

Menus of food were posted on walls in the project and the registered manager told us that that people could input to these via tenant meetings run quarterly by the local authority's housing department. Kitchen staff could cater for different needs of people using the service. One person told us, "The food is alright." Another person said, "I can't cook, I eat here." Staff knew what allergies people had as it was recorded in their care plans. Recommendations from Health Care Professionals, such as speech and language therapists and dieticians, were shared appropriately with staff.

There were systems in place to assist the staff team communicate effectively with each other. Staff used a handover book to pass on relevant information from one shift to the next. Similarly, there was a typed record completed daily by the management team to share relevant information about people that the staff would read. One staff member told us about communicating people's needs, "It's done in the handover book and done when there is handover at 7am. Verbally at lunch time. Duty officer at 5pm prints out what happened during the day."

Staff also completed extra care daily reports that were kept in people's care plans that informed when people had been visited and whether there was anything of note. The registered manager also had access to the local authority's databases and could ensure that information sent to and received from social workers were conveyed appropriately. Staff held handover meetings daily and also held team meetings quarterly. These communication systems assisted the provider deliver effective care and treatment.

People received support to access healthcare services. The warden assisted all tenants of the extra care scheme to access healthcare appointments by arranging them for people, recording them in a diary and reminding people about their appointments. Where necessary staff also supported people to attend healthcare appointments when they could not be supported by relatives or friends. One staff member told us, "Nurses come to us like for [person] they do legs for [person] and we help them. We take people to hospitals occasionally and explain things to doctor and give doctor information." The service also maintained one-page documents of each person using the service for easy access should an emergency

occur. These documents contained people's personal details, their health conditions, brief medical history and their prescribed medicines.

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. People at the service lived in their own property and were not deprived of their liberty by the service. People's capacity was assessed by social workers for the local authority not by anyone employed by the service. One staff member told us about how people's capacity was assessed, "Social Workers do it – I have assisted with one person supporting them [social workers]."

Care plans and care plan reviews recorded whether people were deemed to have capacity and this information was also recorded on the local authority database which the registered manager had access to. Staff had received training on MCA and were able to answer questions asked of them in regards to MCA. A Staff member told us what they would do if a person was unable to make a decision or give consent, "We give examples to them, we go around questions from different sides and ask people different questions and if people can't get decisions we get help from warden and support workers. We [also] speak with carers and families." We saw evidence of one best interest decision meeting where the registered manager had been involved and the principles of the MCA had been adhered to. We saw that care plans and their reviews were signed by people demonstrating their consent, and where signatures could not be given reasons for exclusion were provided.

Is the service caring?

Our findings

People we spoke with told us their privacy and dignity was only respected sometimes. One person told us, "No – not all of them, some of them do [respect our privacy]." They told us that staff did not always knock when entering rooms or knocked and did not wait sufficient time before entering properties. We observed staff knocking on doors before entering properties. Staff we spoke to understood people's privacy and dignity should be respected. One staff member told us, "While doing personal care, it's in their flats and when you're showering someone I try to use a towel to cover their private parts and respect their privacy and dignity. We have conservatory and garden for private conversations."

People's privacy and dignity was not always respected. In the staff room we observed that people's names were written on a white board alongside confidential information about them. This whiteboard was visible to anyone who wished to look through the large window looking onto a communal patio area. We also noted that the staff room door remained unlocked and accessible to people should they wish to enter. The staff room contained handover books and notes containing confidential information about people using the service. This meant there was a possibility that confidential information about people could be obtained and used without their knowledge. We informed the registered manager of our concerns and they acted promptly to ensure that names were removed from the board and told us that a lock would be fitted to the door.

People were treated with kindness and respect and given emotional support when needed. A person told us, "yes they are [caring]." A relative told us they thought the staff caring and acted, "with care and warmth." Whilst another relative said, "Oh yes definitely [they are caring]." We observed people being offered emotional support during our inspection. The service had offered their space to relatives and friends of someone who had recently died. The staff at the service were able to provide emotional support to those who were affected at that time. The management were able to ensure people were being treated with compassion through regular observations of staff.

The service maintained pen portraits of people in their care plans that indicated their likes and dislikes which assisted staff provide care in a personalised manner. Staff, people using the service and the registered manager told us that staff had worked for the provider for many years and knew the people using the service and had built up relationships with them and knew them. This positively impacted on the care provided as staff understood people and were able to provide support needed. Staff we spoke with were able to talk to us about people using the service and how they liked things done. A staff member told us they cared for and treated people "all the same, religion as well, many different colours – it doesn't matter. [we care for them]" They were able to communicate these preferences to each other through their handover systems and by talking with each other.

The registered manager was able to show us compliments that she had received via email from relatives of people using the service. The compliments highlighted the care staff had provided to people using the service from the perspective of relatives. □

The service involved people and their families in decisions about their care. One relative told us, "Yes. First of all we choose here after social services made recommendation for Oakfield Lodge." Another relative added, "Yes, when [person] came here they took charge of them and we wondered whether it was adequate. And it was." Care plans indicated that people and their families were involved in the review and planning of care. Care plans were created by local authority social workers who worked with people and their families and where necessary sought signatures for documentation to indicate agreement with plans made. We also saw minutes of meetings held between family members and the registered manager providing record of decisions made about the care to be provided. This meant people and their relatives were able to choose treatment options and decide what care they wanted.

People were able to express their views. One relative told us, "Involved in occasional meetings about [person]'s care. If we wanted we could make suggestions." A staff member told us that people took part in meetings, "Yes - tenants meeting every 3 months housing officers come from Redbridge." The registered manager and people we spoke with told us that there were meetings held at the service every six months and that they could provide feedback and make suggestions about the service. Whilst these meetings did not specifically focus on the care being offered, the meeting provided a forum to discuss these views. We also observed people visiting the manager's office and talking to the registered manager and other staff in a friendly and open manner. This indicated an environment where expression of views was welcomed.

Is the service responsive?

Our findings

People's concerns and complaints were not always listened to. People knew who to complain to but had mixed views on whether complaints were responded to. One person said, "I know who to complain to but I don't think it would make a difference." Another said, "[Staff]. She would help." A staff member we spoke to said, "Yes. [person] complained about [food]. I told her to go to office." Whilst another staff member said about receiving complaints, "Yes – I've sat and chatted to them about – would you like me to follow it through and bring to supervisor? It did lead to their improvement."

We spoke with the registered manager about complaints generally and we were told that no record of complaints was kept. They said, "We did a complaints folder – but we haven't one anymore due to paper saving." The registered manager told us that complaints were dealt with at the time of being raised. The registered manager conceded it would be beneficial to maintain a log of complaints and told us they would begin to do so again.

Following our inspection the service manager informed us that, "All complaints are logged in the ICasework system via the service improvement manager. Since all systems are now digital there has been a lack in record keeping however since the inspection a complaints book has been set up and this will highlight the actions and outcomes." They also sent us a complaints log that was last used in 2015. All care plans we read contained information on how to make complaints about the service.

People received personalised care that was responsive to their needs. One staff member said, "They're good – its updated info what you need. you need them for personal care." Another staff member told us they work with the social workers around care plan reviews and how they input into the care plan, ". We give examples and they need to come back and they sort it out." We looked at five peoples care plans and each contained relevant information to provide people with care and support. Care plans contained assessments of people's needs, risk assessments and summarised sheets of people's preferences. This meant that anyone providing care knew what they needed to do to support the person and do it in a way they liked.

The service was in regular contact with the social work team who completed assessments and care plan reviews. This relationship led to efficient assessment and review of people's ongoing needs. We spoke with one relative who was able to tell us about an upcoming assessment for their relatives due to their changing needs. The registered manager was able to show us the assessment date on the social worker's data base and how they had arranged for the assessment through contacting the social work team. This relationship ensured that people's ongoing care and treatment was reviewed regularly and their needs met effectively.

We saw that people's assessments and care plans were reviewed as and when necessary often at the direction of the registered manager requesting review from the social workers. The registered manager showed us where changes to peoples' needs meant more care should be provided and how she was supported by social workers to do so. During these reviews social services would meet with people and or their relatives and changes made to the care plan. This meant that the service acted responsively to meet people's care needs.

Care plans also held documentation that was updated daily to indicate the care being provided. This meant there was a record of the care being given to each person, when it was provided and by whom it was provided by. This record ensured that the service could track whether people's needs had been met on a daily basis.

People were supported at the end of their life according to their wishes. Where people chose to remain in their properties at the end of their life care was provided to them that was comforting and dignified. Staff we spoke with had received training on end of life care. One staff member said, "That training was very good." Another staff member told us they understood the end of life care to mean, "Respecting their and family wishes. Respect dignity. Support them best way you can." Care plans were reviewed to follow people's wishes. The service worked with the local clinical commissioning group and social workers to ensure people's end of lives were dignified and pain free.

Is the service well-led?

Our findings

The service's quality assurance arrangements were lacking which meant that improvements were not always identified. The registered manager told us that no audits were completed at the service. They told us they sought quality assurance through quarterly spot checks on people being provided care. Relying solely on this process to provide quality meant that other systems, processes and procedures were left unaudited and there was no opportunity for improvement in large aspects of the care provided.

Our inspection found lack of oversight in regards to training, where the registered manager was unaware of or there was no matrix nor up to date analysis of service training needs. There was a lack of supervision matrix or process for oversight of staff support, which meant the registered manager did not know which staff member was due a supervision. There was a lack of analysis of incidents and accidents and also a lack of a complaints log and analysis of complaints. Not having these systems and processes in place and being unable to audit them meant that there was little possibility to introduce and drive improvements in the service. This in itself meant the service was unable to ensure its own sustainability.

We would expect regular audits to be completed by the provider to assess, monitor and improve the quality and safety of the service. Whilst we are aware the service had transitioned to digital systems within the last 12 months, the provider had not ensured their systems and processes to assess and monitor their service were effective in regards to their regulated activities. The service did not have these systems and processes in place. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on good governance.

Upon completion of our inspection we provided feedback to the registered manager on our inspection findings. The registered manager highlighted to us that the service had transferred most of these functions from paper to digital format and they were unable to inform us as to whether it was possible to provide the assurance or oversight we expected. This indicated to us that the registered manager needed more training on the provider's systems.

Following the inspection, the service manager sent us further information in response to the feedback we had given the registered manager and gave us reassurances regarding the concerns identified. They told us that there was a training matrix that was completed annually in conjunction with the Local Authority's learning and development team. However as stated previously, the registered manager was unaware of this at the time of the inspection. They also said they would be working with North East London Foundation Trust NHS (NELFT) to procure relevant training for the staff team.

The service manager informed us that complaints were audited systematically ad hoc and findings shared with the registered manager and head of service. At the time of inspection the registered manager was not logging any complaints so systematic auditing would have proven difficult. They also said that the registered manager audited Medications Administration Records on an ad hoc basis with findings discussed with staff in supervisions. We were not provided any evidence of these audits or their findings. The service manager told us they would set up a supervision matrix. They also stated that incidents and accidents are reported

digitally and shared with the local authority's health and safety department and following our feedback they would now discuss incidents in team meetings and with relevant people affected by the incident or accident.

People and their relatives had positive opinions about management of the service. Two people we spoke with did not know who the registered manager was but were able to tell us positive things about other members of the management team. Speaking of the registered manager, one person said, "[Registered manager] is alright when [they are here] here." Another person said, "[Registered manager] is outstanding." The staff thought highly of the registered manager and felt supported by them. We observed the registered manager interacting with people, relatives and staff and saw that they were friendly and approachable.

The service provided clear structure with photos of staff and line of management posted on the wall in one of the corridors. People knew who worked at the service and who managed the staff. Staff we spoke to told us, "There is a good work culture". The service had a statement of purpose that we saw in all care plans we looked at. This was coupled with a service user handbook which mapped out what people could expect from the service. Staff we spoke with told us that there was a culture of team work at the service and that what they did well was provide care. This meant that people and staff knew what to expect from the service and the roles staff fulfilled.

People were able to be engaged and involved in the service. People told us they attended meetings about service that were provided by the housing department and they could feedback there about the care provided. One person said, "Tenants meetings. Yes I can make a suggestion.". The staff told us that they attended meetings also and were able to have input into the service. One staff member said, "Staff meetings. We try to do them monthly. sometimes it can be 6- weeks"! and when asked about having a voice in the service, "Yes I do." The service provided surveys that were completed by people and the analysis was shared in the wall in a communal area for all to see. This meant that people and staff had opportunity to input into how the service was run and be involved in how the care was provided.

The service had good links with the local community. The registered manager was able to show us that there were good links with the local mosque, church, school and police.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment.</p>
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014</p>
Personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>The service provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform.</p>