Real Life Options

Real Life Options - West Midlands Supported Living and Outreach Services

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection site visit took place on 4 and 6 September 2018. Both inspection visits were announced. The purpose for our second site visit was to review care records which were not available on day one.

This was the first inspection of Real Life Options - West Midlands Supported Living and Outreach Services since the change of location address from which the service operated.

The service is registered to provide personal care support to people in their own homes. At the time of our inspection 15 people used the service, seven of whom received support with personal care. The service employed 18 care workers, including a team co-ordinator and is located in Coventry in the West Midlands.

Real Life Options - West Midlands Supported Living and Outreach Services provides care and support to people who require their support at pre-arranged times and to people living in two 'supported living' settings who require 24hour support, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

The service had a registered manager. 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.

The provider and registered manager did not have sufficient oversight of the service and had not consistently met their regulatory responsibilities to ensure the quality and safety of the service provided was maintained and improved.

Risks associated with the delivery of people's planned care had not always been assessed to ensure care workers had the information needed to keep people and themselves safe. The provider conducted pre-employment checks prior to care workers starting work, to ensure their suitability to support people in their homes.

The management team and care workers understood how to protect people from abuse and their responsibilities to raise any concerns. People felt safe with the care workers with whom they had built relationships. There were enough care workers to provide people's planned care visits at the times they expected and for the length of time agreed to meet their needs.

The provider had not ensured people's medicines were consistently managed and administered safely and in line with their procedure. Care workers competency to fulfil their role was regularly checked by a member of the management team. People received the support needed to maintain their health and well-being, including timely access to health and social care professionals.

Care workers completed an induction and training the provider considered essential when they joined the service. However, some care workers had not completed the expected Care Certificate in line with nationally recognised guidance. On-going training to ensure care workers updated and refreshed their skills and knowledge was not up to date.

The registered manager understood their responsibility to comply with the relevant requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People were supported to have maximum choice and control of their lives and care workers supported them in the least restrictive way possible.

People's care records were not always up to date or accurate. This meant care workers did not have the written information they needed to keep people and themselves safe, including in an emergency. However, care workers demonstrated a good understanding of the needs and preferences of the people they supported.

Care workers respected people's privacy and dignity and, where possible, promoted their independence. People received their care and support from care workers who were caring and friendly and who understood their needs. People and their representatives were involved in planning and reviewing their care and support.

The provider's systems and management checks to monitor and improve the quality and safety of the service provided were not always effective.

People and relatives were satisfied with the service provided and the way the service was managed. Care workers felt valued by the management team who provided guidance and advice. People knew how to raise any concerns and felt any raised would be listened to and responded to effectively.

We found a breach of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The management of medicines and risks associated with people's care required improvements. People told us they felt safe with care workers and there were enough care workers to provide the support people required. Care workers knew how to safeguard people from the risk of abuse and understood their responsibility to report any concerns.

Is the service effective?

Good

The service was effective.

The registered manager understood their responsibilities under the Mental Capacity Act 2005. Care workers gained people's consent before care was provided. Care workers had been inducted into the service. Care workers had the skills and knowledge to provide the care people required. However, staff induction was not always completed in line with best practice guidance and refresher training was not up to date. Care workers supported people with their nutritional needs and to access health care when needed.

Is the service caring?

Good

The service was caring.

People were supported by care workers who they considered caring and friendly. Care workers supported people to maintain their independence where possible, and ensured they respected people's life style choices and rights to dignity and privacy.

Is the service responsive?

Requires Improvement

The service was consistently responsive.

Some records relating to people's care were not always legible, accurate, up to date and accessible to authorised people, People were supported by care workers they knew who understood their individual needs. Care visits were provided at the times people needed to support them effectively. People were involved in

planning and reviewing their care. Complaints were managed in line with the provider's procedure.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider and registered manager did not have sufficient oversight of the service to ensure the quality and safety of the service in line with their regulatory responsibilities. People and relatives were satisfied with the service provided and the way the service was managed. Care workers felt valued and supported by the management team.

Real Life Options - West Midlands Supported Living and Outreach 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.

This inspection site visits took place on 4 and 6 September 2018. Both inspection visits were announced. The provider was given 48 hours' notice of our first visit because the service provides a domiciliary care and supported living service and we needed to be sure staff and the registered manager would be available to speak with us about the service. The provider was given 24 hours' notice of our second visit to ensure records associated with people's care were available for us to review.

The inspection team consisted of one inspector.

This was the first time Real Life Options - West Midlands Supported Living and Outreach Services had been inspected under its current registration with the Care Quality Commission in May 2017. The service had previously operated from a different location.

Before our inspection visit we looked at information received from statutory notifications the provider had sent to us, and contacted commissioners of the service. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or the NHS. They had no further information to tell us that we were not already aware of.

We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give us some key information about the service, what the service does well and improvements they plan to make. During our visit we found the PIR did not always accurately reflect the way the service operated.

We spoke with three people and three relatives via the telephone to obtain their views of the service provided.

During the inspection we visited and spoke with the registered manager, the team co-ordinator and three care workers. We looked at two people's care records and other records related to people's care, including medicine and daily records. This was to see how people were cared for and supported and to assess whether people's care delivery matched their records.

We reviewed three staff files to check staff were recruited safely and were trained to deliver the care and support people required. We also looked at records of the checks the provider and registered manager made to assure themselves people received a good quality, safe service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe when being supported by care workers who visited them. One person told us they felt safe because their care worker was always 'checking on them'. Another person commented, "What makes me feel safe is they [care workers] explained 'things' so I don't worry."

The provider's PIR stated, 'Risk Assessments are in place to promote the people we support's independence, choice and control to manage risk…' However, during our inspection we found this was not an accurate reflection of the way the service managed risk.

Whilst we saw there were procedures to identify potential risks related to people's care, such as risks in their home or risks to the person, some known risks had not been assessed. For example, records showed a speech and language therapist (SALT) had assessed a person as at risk of choking. However, a risk assessment had not been completed to inform care workers how to manage and reduce this risk. SALT are health care professionals who work with people who have difficulties with communication, eating, drinking or swallowing.

Another person's care plan stated they were at risk of their skin becoming sore. Records completed by health care professionals included the actions care workers needed to take to manage and reduce this risk. However, this information had not been transferred to the person's care plan and a risk assessment had not been completed.

This meant care workers, particularly agency staff, did not have the information they needed to ensure risk was consistently managed to keep people safe. We discussed our findings with the registered manager and team co-ordinator who acknowledged our concerns. The registered manager told us they would prioritise the completion of risk assessments.

Other risk assessments we reviewed were up to date, and included detailed information for care workers to follow to manage and reduce each risk. For example, one person needed specialist equipment to transfer from their bed to their chair. The assessment detailed the equipment needed, how this should be used and the number of care workers required to support the person safely.

Despite omissions in records discussions with care workers demonstrated they knew about the risks associated with people's care and how these were to be managed. One told us, "We keep them [people] safe because we understand risk. We explain and discuss things with them (people) so they understand as well." Another care worker told us any potential new risks were reported to the management team so they could be assessed. They added, "If anything changes it's written in the communication book or the team co-ordinator rings or messages on our work phone to give us an update."

We looked at how medicines were managed by the service.

Medication administration records (MARs) we reviewed on the first day of our inspection showed medicines

had been administered and signed for by care workers at the required specified time. This included medicines prescribed 'as required' (PRN). PRN protocols were available to inform care workers what each medicine had been prescribed for, signs which may indicate the medicine was needed and how often if should be given. This ensured people did not receive too much or too little of this type of medicine

However, records we reviewed on our second inspection visit showed people's medicines were not safely and consistently managed in line with the provider's procedure.

The provider's medication policy stated, 'All medication administered by staff must be signed for by the person administering the medication. This should be done using a Medication Administration Record Sheet. Where these are not supplied by the pharmacy as part of a monitored dosage system, appropriate documentation must be used.'

We saw district nursing records included information about a cream (also known as topical applications) they had prescribed for care workers to apply to a person's skin when providing support with personal care. However, we found this cream was not detailed on the person's MAR and care workers were not completing records to show the cream had been applied. This meant the provider could not be assured topical applications were being applied safely and as prescribed. The team co-ordinator told us, "It's not on the MAR because it comes from a different chemist." Following our inspection, the registered manager contacted us to confirm a MAR was now in place.

Other MARs showed some people were prescribed topical applications to be applied directly to their skin. MARs directed care worker to 'SEE TOPICAL CHARTS' for instructions about which part of the person's body these should be applied too. When we asked to see these charts the team co-ordinator told us, "They are in the service [people's homes] and can't be taken out." We asked to see historic copies of completed records but were told these could not be located at the time of our visit.

One person's medicine was prescribed in the form of a patch which was applied to their skin. Instructions on the MAR stated, 'change one patch on a different area of the skin every 72 hours'. Varying the site where patches are applied reduces the risk of skin becoming sore from repeated applications in the same place. Keeping a record of where each patch is applied is important to prevent this. However, we found care workers were not keeping a record of where each patch had been applied. This meant we could not be sure care workers had the information they needed to follow the prescribing instructions for this medicine. The team co-ordinator told us care worker had previously documented this information on the rear of the MAR but following a change to MARs there was nowhere to record the information. They gave assurance they would take action to address this.

Records confirmed audits of MARs had been completed at regular intervals. However, these had not always identified where improvement was required. For example, a weekly audit completed by a care worker had not identified a recording omission or that a medicine had not been administered in line with the prescribing instructions. We highlighted this to the registered manager. They told us this was an 'oversight' and they would ensure all future audits were checked by the management team.

Despite these omissions people told us they received their medicines at the times they needed. One said, "My carers help me with my tablets. I always get them." Another person explained they administered their own medicine but relied on their care workers to 'remind them'. They said, "If they [care workers] didn't remind me I would probably forget."

Training records showed care workers received medicine training and their practice was observed to make

sure they continued to be competent to administer people's medicine safely. A newly recruited care worker told us, "I can't do medication yet because I haven't done all my training or been assessed."

Care workers had received training in how to protect people from abuse and understood how to safeguard people from harm. We gave care workers different scenarios where a person was at potential risk of abuse. They knew their responsibilities were to report their concerns to the management team. One told us, "My priority would be to make sure the person was safe and then report it to the manager." They added, "If I was still worried I would go to a higher manager or the police or CQC (Care Quality Commission)."

Discussion with the registered manager confirmed they understood their responsibilities to inform the local authority safeguarding team and CQC if there were any concerns about people's safety. Records showed the provider managed safeguarding concerns in accordance with their policies and procedures which helped to keep people safe.

People were protected by the provider's recruitment practices which minimised risks to people's safety. The provider ensured, as far as possible, only staff of suitable character were employed. Prior to staff starting work at the service, the provider checked their suitability by contacting their previous employers and the Disclosure and Barring Service (DBS). The DBS is a national agency that keeps records of criminal convictions. Care workers told us they had to wait for DBS checks and references to come through before they started working at the service. Records confirmed this.

There were enough care workers available to support people at the times agreed and people received the support they needed from care workers they knew. One person told us, "I know all my carers. They come every day at 10 o'clock." A relative explained how any change in routine caused their family member to become anxious and upset. They said, "That's why they [person] have help from staff they know and at set times. It's important."

Care workers confirmed they supported the same people at pre-agreed times and stayed for the length of time allocated. One told us, "Each person is supported by a team. We get our rota in advance so we know exactly where we need to be and for how long. Routine is important for most of the people we support that's why we do the same visits."

The registered manager and team co-ordinator checked people had received the care they needed at the times they expected and for the length of time agreed through visits to people and monthly checks of 'daily support notes' (records completed by care workers at each visit).

Records confirmed care workers' rotas were prepared in advance and showed care workers had visited the same people at the expected times. Where care workers or the management team were unable to cover unexpected staff absences the service used agency staff. The registered manager said, "Before we agree an agency worker we review their profile to ensure their skills match the needs of the person they would support." They added, "Consistency is important and using the same agency ensures this."

People told us care workers followed good infection control practice by using disposable gloves and aprons, when needed. Discussion with care workers demonstrated a good understanding of infection control procedures. One told us, "The use of aprons and gloves is key to reducing cross infection."

Care workers demonstrated they understood how to keep people safe in the event of a fire or other emergency. One told us, "They [people in supported living environment] have PEEPs [personal emergency evacuations plans] for us to follow. PEEPs provide staff and the emergency services with the information

needed to support people safely in the event of a fire, or other emergency.

However, when we asked the registered manager about the services emergency contingency plan in the event of them not being able to provide a service, for example in the event of widespread staff sickness or extreme weather conditions, they told us, "It's in my head… even though it's not down in black and white we would know what to do." They told us a 'local plan' had not been written because it needed to be informed by the provider's emergency contingency plan which was under review.

Accidents and incidents were logged and appropriate action taken at the time to support people safely and to check for trends or patterns in incidents which took place. The registered manager told us, accident and incidents from all the provider's services were reviewed by head office. They explained any themes identified by the head office analysis were shared at managers meetings so any learning or action needed could be discussed and agreed.

Good

Is the service effective?

Our findings

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.

We checked whether the service was working within the principles of the MCA. We found the registered manager understood the relevant requirements and their responsibilities under the Act. Records confirmed where the need for restrictions on people's liberty had been identified, the registered manager had made DoLS applications to the relevant authorities so they could be legally authorised. At the time of our inspection the registered manager was waiting for the outcome of the applications to be confirmed.

Care workers told us they had received training to help them understand the principles of the MCA. One commented, "It's about their [people's] rights and capacity. About their capacity to fully or partially understanding the decisions that need to be made." They added, "They have the right to make their own decisions and to get support if they can't." Discussion with care workers demonstrated they knew about the DoLS applications that had been made and the actions they needed to take to keep people safe.

People's care records contained information about people's capacity to make decisions. Where people had been assessed as not having capacity to make complex decisions, records showed who had the legal authority to make decisions in the person's best interests. For example, one person's next of kin had been 'legally' appointed to make decisions on the person's behalf.

People told us care workers sought permission before providing care and support. One person said, "They [care workers] always ask me what I would like and what they should do." Discussion with care workers demonstrated a good understating of the principles of the MCA, including the importance of obtaining people's consent.

The registered manager explained before agreeing to provide a service one of the management team visited the person and their family, or representative to carry out a detailed assessment. They explained this gave the service the opportunity to assess if care workers had the necessary knowledge and skills to meet the person's needs and expectations. One person told us, "[Registered manager] asked me lots of questions and I told them what I wanted." Records showed initial assessment included gathering information about people's life style choices, beliefs, needs and preferences.

People and relatives were confident their care workers had the skills and knowledge needed to meet their needs. One person told us their care worker, 'sang to them' which made them feel relaxed. A relative commented, "From what I have seen I would say the staff know what they are doing. They are very good." A care worker told us, "The training we get is good." They added, "The management observe us to check we are doing things right."

The provider's PIR stated, 'Real Life Options has a learning and development team responsible for ensuring that all staff have up-to-date training in place responding to mandatory and service specific requirements and is refreshed as required via either class room based or e-learning'.

However, we found refresher training for some care workers was not up to date, including Safeguarding, Mental Capacity and DoLS and understanding equality and diversity. We discussed this with the registered manager. They told us this was because the provider's 'learning and development team' was now responsible for maintaining training records. They added, "We [management team] don't have control. I'm not confident these records are up to date. I think staff have done some training not shown."

Care workers told us they completed an induction when they started work at the service. This included working alongside an experienced staff member, and completing training the provider considered essential to meet the needs of people who used the service. One care worker described their induction as 'really good' because it had given them the opportunity to meet the people they would support and to develop a clearer understanding of their role and responsibilities.

The provider's induction for new staff was linked to the 'Care Certificate'. The Care Certificate is nationally recognised guidance for effective induction procedures which introduced in 2015. It assesses staff against an agreed set of standards during which they have to demonstrate they have the knowledge, skills and behaviours expected of specific job roles in social care sectors.

We spoke with care workers about the Care Certificate. One who had no previous experience of working in a social care setting told us they could not recall undertaking the Care Certificate as part of their induction. We asked the registered manager about this. They told us they were 'not sure' if the Care Certificate had been completed or not.

This meant the registered manager had not ensured care worker induction and on-going training was provided in line with the provider's induction and training processes. They gave assurance this would be addressed.

Where needed people received support to maintain their health and wellbeing. One person told us they were due to visit the dentist with their care worker. They said, "[Care worker] has to remind me because I forget." A relative described how care workers had telephoned for an ambulance when their family member was unwell. They added, "There was no hanging about they [care worker] got [name] straight to hospital."

Records confirmed the involvement of health and social care professionals in people's individual care on an on-going and timely basis. For example, there was information that confirmed contact with physiotherapists, social workers, district nurses, SALT and occupational therapists.

The service worked in partnerships with other health and social care professionals to support people. For example, the team co-ordinator described how they had initiated joint working with a person's GP, community nurses, a mental health team and occupational therapist to support a person to reduce their anxiety levels. They added, "We are looking outside the box…we are trying different ways to provide stimulation using feel, touch and smell."

People's nutritional needs were met by care workers if this was part of their planned care. One person told us they did not feel safe using the cooker so care workers cooked their meals. They said, "We chat about what I fancy and they [care workers] do it for me. I don't want to use the cooker." Care worker knew people's food and drink preferences. One told us, [Person] loves coffee it's their favourite drink. They get a coffee in

bed to start the day. It makes them [person] smile."

Good

Is the service caring?

Our findings

People were supported by care workers who they described as caring and friendly. One person told us, "My carers are lovely. I can't fault them." Another person told us their care workers spent time chatting and sharing a joke which the person 'looked forward' too. A relative explained their family member was able to 'do things for themselves' because care workers were patient and provided encouragement. They added, "They are never in a rush and really take their time."

Care workers understood the importance of enabling people to remain independent. One explained how they used verbal prompts to encourage a person to shower. They added, "Of course, the easy option is for me to do it but that's not right. With a little encouragement [person] can do it." Another care worker commented, "A key part of our role is to assist and encourage. We don't take away their [people's] independence. That would be wrong."

People were supported and encouraged to make choices about their day to day lives. Care workers respected the choices and decisions people made. One person told us they liked to spend their time going to church and shopping. Discussion with care workers confirmed the person was regularly supported with these activities.

Care workers had developed positive, respectful and caring relationships with people they supported and were knowledgeable about their individual needs and preferences. One person said, "My carer are my friends. They look after me." Another described their care workers as their 'family'. A care worker commented, "We support the same people. We spend lots of time together talking, listening, laughing. You really to get to know them [people]."

Care workers understood the importance of promoting equality and human rights as part of a caring approach. One care worker told us, "If I'm at work I take away my beliefs and values. I learn what is important to the person. Then I can use this to build trust and a relationship. I work at making them [people] feel comfortable so they can tell me what's important."

People told us their privacy and dignity was maintained. One person said, "My carer knocks the door before they come in." Care workers understood the importance of respecting and ensuring people's privacy and dignity was maintained. One explained they did this by closing doors and curtains before assisting people with personal care.

Care workers understood the importance of maintaining confidentiality. One commented, "We [care workers] would never share information or have a discussion in one of the communal areas (supported living) we go into the office."

We asked care workers what providing a caring service meant to them. We were told, "Making sure they [people] feel important and loved." and "Helping them [people] live the life they want by doing everything to make sure they are safe, happy and comfortable."

Requires Improvement

Is the service responsive?

Our findings

When we visited the service on 4 September 2018 the registered manager informed us people's care records were not available for us to review because they were kept in people's homes. They explained the reason for this was the 'logistical' challenge of transporting care records back to the office due to the geographical location of the homes of people being supported.

The team co-ordinator told us electronic copies of 'some' records were available but these were not up to date. The registered manager added, "Care records are constantly being updated. Our priority is to make sure support workers [care workers] are fully aware of the changes. We have overlooked making sure the office copies are updated."

We returned to the office on 6 September 2018 to review two people's care records.

We found some care records were not up to date. For example, one person had two files each containing copies of the same support plan. Both plans contained multiple typed and handwritten amendments. It was not clear what information was current and what had been deleted. We discussed this with the management team. They explained the files were being updated following a review of the person's care with their family. However, when we asked what date the review had taken place we were told April 2018.

Other care plans contained inaccurate information. For example, care workers told us one person needed a care worker to support them to take their medicine. This conflicted with the information in the person's care plan which detailed the need for support from two care workers. When we asked the team leader about this they said, "They [person] don't need two staff. It was something the previous manager insisted on." The team leader confirmed the previous manager had left the service over 12 months ago.

One person was known to display behaviour that could be challenging to themselves and others. When we reviewed the person's care records we identified there was no care plan or risk assessment in place to inform staff how to manage this risk. The registered manager acknowledged this, they said, "Because the staff know what to do we haven't developed a care plan." Discussions with care workers assured us they understood how to support the person. One told us, "[Person] loves music so we use this as a distraction. It works."

We were concerned the omissions we found in care records meant care workers, particularly agency workers, did not have the correct information needed to provide care and support safely and consistently. The registered manager told us 'organisational expectations' to focus on other projects and developments had diverted their attention away from care records. They acknowledged our concerns and said, "I can give you my absolute assurance record keeping is going to be a priority for us to address, starting now."

In contrast other care plans contained information about people's life histories, their likes and dislikes, cultural and religious beliefs. People's needs and preferred routines were detailed which supported care workers to provide personalised care. For example, what people preferred to drink and what items of

clothing they liked to wear. Records of calls completed by care workers confirmed these instructions had been followed. People and relatives confirmed they were involved in planning and reviewing their care and support.

People and relatives told us they were very satisfied with service they received because the service was reliable, provided by care workers they knew, and who understood their needs and preferences. Comments included, "There is a small team of carers so [person] know them all. That's important." "My carers know me and what I like." and, "We are very happy with everything. The carers, the call times and the support [person] gets."

Discussion with care workers demonstrated they had a good understanding of people's care and support needs. For example, one care worker explained when a person was thirsty they licked their lips. Care workers told us they read people's care plans before undertaking a care call which provided them with 'all the information we need to know." One care worker added, "We use them [care plans] as a starting point to understand the person and their needs. Then we learn more about them at each visit."

Visit schedules confirmed, care calls were planned in advance, at the times agreed and people were allocated regular care workers. Care workers told us they were allocated sufficient time to carry out care and support calls and had flexibility to stay longer if required. One said, "If we need to stay longer or we need extra time we speak with [the manager]. It has never been a problem."

The Accessible Information Standard (AIS) is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. We spoke to the registered manager about how they ensured information was accessible for all people using the service. They told us information about the service was available in a range of different formats, including pictorial and large print. Records showed the team co-ordinator had made referrals to the SALT to support the service to improve and better understand how best to communicate with some of the people being supported.

People were allocated 'keyworkers' and these staff members were responsible for overseeing people's care and support. This provided people with a consistent named worker. One person told us, "My keyworker is my favourite. I really like her.". The team co-ordinator explained keyworkers had additional responsibilities including arranging and attending meetings, contact with family and ensuring people's wishes and needs were met.

We looked at how complaints were managed by the provider. People and relatives told us they had no complaints, but knew how to complain and would be confident to raise any concerns with the management team, or care workers if they needed to. One person told us, "I would go straight to [registered manager] he would sort it."

People were provided with a copy of the provider's complaint procedure, which was available in a range of formats including 'easy read' when the service started. Easy Read information is for people who have difficulty reading and understanding written information.

Care workers told us they would refer any concerns people raised to the team leader and they were confident concerns would be dealt with effectively.

Records showed the service had received one complaint which had been managed in line with the provider's complaints procedure.

Requires Improvement

Is the service well-led?

Our findings

The provider and registered manager did not have sufficient oversight of the service and had not consistently met their regulatory responsibilities to ensure the quality and safety of the service provided was maintained and improved.

The registered manager had not maintained people's records in line with regulatory requirements. During our inspection we found records and copies of records relating to people's care were not up to date, complete and accessible to authorised people.

The provider's audits and checks to assess and monitor the quality of the service provided had been completed but were not always effective. For example, weekly audits of medicines had not identified the medicine management issues we found. The provider had not assured themselves medicines were being safely managed in line with their procedures

The registered manager had not maintained an overview of care workers inductions and on-going training. Some care workers refresher training was not up to date and inductions had not always been completed in line with the provider's training policy and procedure, which reflected expected national best practice guidance.

The provider's 'service improvement plan' was not effective in supporting the service to make timely improvements and did not prioritise the actions needed to ensure people's safety. For example, on 19 October 2017 the plan identified the need to ensure 'Information at the registered office should replicate information kept in the service user's home' and,
'Ensure staff are aware that amendments [to care records] should be dated and signed'. Both actions had been signed as completed by the registered manager in August 2018. This conflicted with our inspection findings which showed these actions remained outstanding.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance

The service had a registered manager. 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.

People and relatives were satisfied with the service provided and spoke highly of the management team. One relative described the registered manager as 'a breath of fresh air'. They told us they found the registered manager and team co-ordinator to be very responsive and approachable. Another relative said, "It's a good service. [Person] is looked after well."

The service had a clear management structure, including the registered manager and the team co-ordinator,

who deputised in their absence. The registered manager told us they worked 'very closely' with the team co-ordinator with whom they had a very positive relationship. They added, "We are constantly communicating round operational issues. We are pro-active not reactive. We make sure we are available to support staff …"

The registered manager was also supported by one of the provider's Head of Operations through regular telephone contacts and visits to the office. They added, "They [head of operations] are always available, even at weekends. The support is very good."

The registered manager kept their knowledge of current social care issues updated. They explained they did this through links to social care websites, attendance at Health and Social care conferences and registered manager forums. This meant they had the opportunity to keep up-to-date with regulatory changes, to share learning and good practice and ideas for improvement.

Care workers spoke highly of the management team. Comments included, "[Team co-ordinator] is approachable. You can ask anything and you get an answer." "The manager listens and values what we say." "The manager is 'brilliant'. If you get stuck you can ring and always get support. The way they explain things is really helpful." and "I'm happy with my manager. He has high standards and can be strict about that, but he is also very helpful and supportive."

In addition to daily contacts care workers told us they had regular individual and team meetings with the management team. One care worker described their individual meetings as 'helpful' because they talked about any concerns or development needs. Another told us during team meetings they were able to speak 'openly and honestly'. They added, "If you have a suggestion about doing things differently you can say so."

We saw the latest meeting minutes dated July 2018 for care workers who supported people in one of the supported living environments. However, no meetings had been held with other care workers during 2018. The registered manager told us this was because they had found 'informal meeting' more effective and these meeting were not recorded.

The provider operated an 'on-call' system so care workers could seek management support outside of normal office hours. Care workers told us this was important if they needed to respond to emergencies because they provided care and support to people 24 hours a day. One care worker said, "Personally I have never used 'on call' but I know others [care workers] have and it worked well."

The registered manager understood some of the requirements of their registration. For example, they had notified us about important events and incidents that had occurred and had completed the Provider Information Return (PIR) as required by Regulations. However, we found the information in the PIR was not always an accurate assessment of how the service operated.

The provider invited people to share their views about the quality of the service and any areas where improvement could be made through an annual 'Customer Satisfaction Survey'. The latest survey was issued in May 2018 and was in the process of being analysed by head office.
The registered manager told us they were planning to use feedback from this to further develop the service and address areas where improvements could be made.

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	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (c) (e) HSCA RA Regulations 2014. Good governance The provider had not ensured they had effective systems in place to assess, monitor and improve the quality and safety of the service provided. The provider had not ensured nationally recognised guidance in relation to inductions for some new care workers had been implemented. Records relating to people's care were not always accessible to authorised people. Some records related to people's care were not legible, accurate and up to date. The provider had not ensured identified service improvement had been made without delay.