Hales Group Limited

Redwood Glades

Inspection report

Leads Road
Hull
North Humberside
HU7 0BY

Tel: 01482235402

Date of inspection visit:
12 March 2018
13 March 2018

Date of publication:
30 May 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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 12 and 13 March 2018 and was announced. This was the first inspection since the service was registered with the Care Quality Commission (CQC). We gave the provider, Hales Group Limited, 48 hours' notice of our inspection. This was because the location provided a domiciliary care service and we needed to be sure the registered manager and staff would be available to support the inspection process.

This service provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is rented, and is the occupant's own home. People's care and housing are provided under separate contractual agreements. The CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

People who used the service lived in a large building which had 156 individual flats. At the time of the inspection, there were 10 vacant flats. Hales Group Limited provided domiciliary care to people with a range of needs. These included people with mental health needs, physical difficulties, those who were living with dementia, older frail people or those who had a learning disability. Not everyone using Redwood Glades received a regulated activity. The CQC only inspects the service being received by people provided with 'personal care', for example, help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided. At the time of the inspection, 118 people were receiving the regulated activity of personal care from Hales Group Limited.

The service had a registered manager in post. A registered manager is a person who has registered with the CQC 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 Act 2008 and associated regulations about how the service is run.

During this inspection, we identified shortfalls throughout the service in relation to medicines management, quality monitoring of the service, records and staff support, supervision and training.

We found people had not always received their medicines as prescribed. There had been a number of errors with medicines management and staff were to receive additional training and competency checks.

Improvements were required in risk management to ensure all areas of risk were identified and included in care plans to help staff minimise risk of incidents and accidents.

The unit manager told us part of the internal quality monitoring system had ceased in October 2017 as they concentrated on an influx of admissions to Redwood Glades. This meant any audits that were completed were carried out in a reactive rather than a planned way, for example to address errors in medicines management. This meant care plan and risk assessment deficits had not been identified and addressed

quickly. Seven day and six-week reviews with people who used the service had taken place, which was part of the audit system.

Records were not comprehensive, especially those describing the care required to support people in a safe way. There were also some gaps in recording decisions relating to people's capacity. We have made a recommendation about the application of the Mental Capacity Act 2005.

The above issues were breaches of Regulation 12 Safe Care and Treatment and Regulation 17 Good Governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. You can see what action we told the provider to take at the back of the full version of the report.

Improvements were needed to make sure staff received formal supervision to check their progress and development. We have made a recommendation about this.

Staff were recruited safely and in numbers sufficient to meet people's needs. The registered manager told us staff were recruited and allocated to calls on the basis of the number of care hours requested by commissioners. There had been an initial issue when admissions to the service outpaced staff recruitment, but the registered manager told us they were fully staffed now and admissions almost completed. There were concerns raised by some people about the timings of care calls and the length of time staff were given between calls to ensure this gave them sufficient time to move about the building. The registered manager told us they would look into this.

Staff had received training in safeguarding people from the risk of abuse. They knew the signs and symptoms to look out for and how to alert relevant people.

Some people told us there had been issues with staff attitudes and, at times, their privacy had not been respected and preferences not adhered to. The registered manager was aware of this and had arranged additional training for staff. Other people were very happy with the care provided by staff and had built up good relationships with them.

Staff supported people to access healthcare professionals when required and monitored their health and nutritional intake when risk had been identified. Some people required only minimal assistance with meal provisions, whilst others needed close monitoring to ensure their meals were eaten and they had sufficient fluids. Staff completed food and fluid monitoring charts for those people at risk.

The provider had a complaints policy and procedure, which was given to people when they accessed the service. People told us they felt able to raise concerns or they would speak to their relatives to raise them on their behalf. There were concerns that the office was not a private place to discuss complaints. The registered manager told us the staff training room was available for private discussions when requested and there was a weekly drop in session for people who used the service and relatives to allow individuals to discuss concerns or complaints.

The registered manager, unit manager and staff told us the culture of the organisation was open and they would be able to raise issues with senior management if required. There was an organisational structure with tiers of management and incentives to assist with staff retention.

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.

Not all people had received their medicines as prescribed.

Not all risks were assessed and planned appropriately which placed people at risk of potential harm. Staff knew how to safeguard people from the risk of abuse and who to contact if they had concerns.

Employment checks were carried out before staff started work and there were sufficient numbers of staff deployed. However, the timings in-between calls required adjustment to ensure staff did not cut short the care and support calls to people.

Staff used personal, protective equipment to assist them in preventing the spread of infections.

Is the service effective?

Requires Improvement

The service was not consistently effective.

There were gaps in the training record and a formal supervision system had not been fully developed.

People told us staff gained consent before carrying out care tasks. Information within care plans did not always detail how people who had been assessed as lacking capacity may be affected in their decision-making processes.

Staff supported people to maintain their health and nutritional intake. They liaised with health professionals when required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

There were mixed comments from people who used the service and their relatives about staff attitudes and practice. There were also mixed comments about how people's privacy and dignity were maintained.

Communication between staff and people who used the service regarding timings or changes to care calls requires improvement.

Personal information was held securely either in the person's own home or in locked cupboards in the main office.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People who used the service had assessments and care plans. The care plans and risk management plans were basic and required more information to guide staff on how to meet people's needs.

Although most people were happy with the care delivered, there were some instances when their preferences had not been adhered to.

The provider had a complaints policy and procedure. Complaints were logged and investigated.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The quality monitoring system had not been embedded into practice yet, as the service was new. There had not been any monthly self-assessments regarding monitoring quality since October 2017. The impact was that shortfalls in recording had not been addressed.

The registered manager and unit manager had been open and honest about issues and were committed to improving the service.

The culture of the organisation was open and supportive.

Redwood Glades

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.

Inspection site visit activity started on 12 March 2018 and ended on 26 March 2018. We gave the service 48 hours' notice of the inspection site visits because the location is a domiciliary care service and we needed to ensure someone would be in the office. As there had been several complaints and incidents relating to aspects of care and medicines management since registration of the service on 31 July 2017, we decided to bring forward the scheduled comprehensive inspection.

The inspection included visits to the office on 12 and 13 March 2018 to see the registered manager and office staff, to review care records, documents relating to the management of the service, and policies and procedures. We also had discussions with people who used the service, their relatives and staff. In the few days following the inspection site visits we made telephone calls to more people who used the service.

The inspection team consisted of two adult social care inspectors on each of the two inspection site visit days. Representatives from the contracts and commissioning team visited the service on the same days as the inspection to complete an audit.

Before our inspections, we usually check the Provider Information Return (PIR). 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. However, we had not yet requested PIR information from the provider. We looked at the notifications we had received from the service and reviewed all the intelligence CQC held, to help inform us about the level of risk for this service.

We contacted the local safeguarding and contracts and commissioning teams to request their views of the service. We also liaised with four health and social care professionals involved with supporting some people who used the service.

During the inspection, we spoke with 20 people who used the service and three of their relatives. We looked at care records for 11 people and other important documentation including; medication administration records (MARS) and monitoring charts for food and fluids and behaviour that could be challenging to others.

We also spoke with the registered manager, the area manager and five care staff. Nine other care staff, including two team leaders, provided additional information during the inspection site visits. We also looked at recruitment files for four members of staff, staff supervision, appraisal and training records, as well as other records used in the management and monitoring of the service.

Requires Improvement

Is the service safe?

Our findings

Most people told us they felt safe with the staff. Comments included, "Yes, totally safe. If you have any problems you can go to the office downstairs or if you pull the cord, they ring through straight away to ask if you are ok", "Not really, they don't really understand my condition" and "There are one or two nice staff."

Relatives stated, "I think they are safe here; there is a lifeline and it goes straight to the seniors."

Health and social care professionals said, "Yes, it is safe. However, the concerns I have are regarding staffing; they are understaffed", "Some people have stated they are supposed to have an hour and the carers rush to leave early as they have other people to see" and "I think the service is safe."

People had not always received their medicines as prescribed. Before the inspection, we had received information about five incidents related to medicines management. These referred to people not receiving them at the correct time and errors in administration. The complaint records showed a further three concerns raised by relatives about medicines management. On one occasion, a person received double the amount of a medicine for 12 days. When the error was highlighted on the person's medication administration record (MAR), they continued to receive the wrong dose for a further two days. The registered manager had not been made aware of this error.

Another person was prescribed a pain relief patch to be applied every 72 hours. The recording of applications was very confusing and it was unclear if the person had received them as prescribed. The same person was prescribed a short course of a medicine which started on 9 February 2018. They were administered this once on the start date and then staff recorded they could not locate it so there was no record of the person receiving it for the next two weeks.

There were gaps on the MARs with no codes to indicate why the medicine had been omitted. Some people had run out of medicines as stock levels had not been monitored effectively. There was a lack of guidance for staff with some medicines, for example, staff had recorded on one person's MAR that they could not apply creams as they had no direction as to where it was needed.

Comments from relatives included, "There were problems with medication and staff not reading the labels. I reported it three times, but the same issue is happening again." Other relatives reported concerns with medicines management directly to the registered manager or to the local authority to address.

Not having systems in place to ensure the safe management of medicines was a breach of Regulation 12 (Safe care and treatment) 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 this report.

Following the medicines errors staff received competency checks and supervision meetings.

Not all risks were managed appropriately, which put people at increased risk of potential harm. Risk

assessments were carried out for some areas such as self-administration of medicines, visits to the community, and the environment, which covered issues such as security, utilities and hazards. Risk assessments had not been completed for the use of specific equipment such as hoists, wheelchairs and bed rails. One person had a history of falls, poor nutritional intake and urinary tract infections before taking up their tenancy and receiving a service. However, they did not have risk assessments for these areas completed. Some people were at risk of specific conditions such as diabetes, dementia, epilepsy, sight difficulties, aspirating food, mental health needs and behaviours which could be challenging, but there were no risk assessments, and in some cases no care plans for the health care needs, to ensure these were addressed fully. A relative told us they had concerns as their family member had risks associated with falls, nutrition and hydration, but did not have risk assessments in place.

Not having systems in place to fully manage risk was a breach of Regulation 12 (Safe care and treatment) 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 this report.

Staff confirmed they had completed safeguarding training and described the different types of abuse and the measures to take if they witnessed abuse or poor practice. The registered manager had contacted the local safeguarding team for advice and to report incidents as required. There were safeguarding policies and procedures in place to guide staff.

Employment checks had been carried out before staff started work at the service. These included an application form, references, an interview and a check with the Disclosure and Barring Service (DBS). Checks with the DBS include any police cautions or convictions and assist providers to make safer recruitment decisions. One staff file had missing references and the registered manager ensured this was addressed with head office. Staff received probationary meetings to check their progress after six month of employment or sooner if there were any concerns.

There were sufficient numbers of staff deployed at the service. There was a 'core' staff of four team leaders who were based at the office in Redwood Glades day and night. These staff were available to answer the emergency call system for any person who lived in Redwood Glades whether they received a funded care package or just required someone there for emergencies. They were also on site to support and advise the care workers providing support to people. The registered manager told us the amount of care workers on duty at any time was calculated on the number of hours people were funded for. They used a dependency level tool devised by the local authority to ensure the tenants of Redwood Glades did not have needs that exceeded a specific and balanced ratio. For example, the service aimed for a ratio of 20% of people with low needs, and 40% each of people with medium and high needs. The registered manager told us these ratios were not exceeded at the time of our inspection.

There were mixed comments from staff about whether there was sufficient time to complete tasks. Most commented, time allotted for each person was sufficient but some staff said they felt rushed when supporting people and there was limited or no time indicated between calls within the service. As the service was a large building with two floors, there was a lot of ground to cover on each care round. A selection of call records was checked and a small number confirmed a lack of planned interval time between calls. This was discussed with the registered manager who stated there should be time available between calls for staff to get to the next person. They showed us records where there were several minutes allowed between calls. They told us they would monitor this and ensure there was appropriate time for staff between all calls in future. A team leader told us they would contact the local authority to request an increase in call time if staff reported they had insufficient time to complete tasks.

Staff had access to personal, protective equipment such as gloves, aprons and hand sanitiser to use when supporting people with personal care tasks or the preparation of meals. Staff had completed infection prevention and control training during their induction.

Requires Improvement

Is the service effective?

Our findings

Before the inspection, we had received concerns from some relatives about the level of staff skills and knowledge required to support the range of people's assessed needs. The training records showed most staff had completed an induction, which was aligned to the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected for people in health and social care roles. The induction was very comprehensive and completed over five days. Following the five days induction, we were told staff continued to complete the Care Certificate sections over the next 11 weeks to consolidate knowledge. The unit manager was unable to provide information on how many staff had enrolled on the Care Certificate but this was to be collated.

Following the inspection, the registered manager provided evidence that all staff had completed the five-day induction.

Staff comments about induction included, "Very informative and you could talk to the trainer as their experience showed throughout the induction" and "I felt the induction was in-depth on the basics. I didn't do any shadowing and wasn't supernumerary." There was an inconsistency regarding whether staff completed shadowing shifts with more experienced staff as part of their induction. Some reported they did, but others stated they did not have shadow shifts and went straight into 'care calls'. The training record was incomplete regarding the numbers of staff who had completed shadowing shifts, which was mentioned to the registered manager to address.

The training records showed staff had access to training mainly in the induction week. The registered manager told us updates to training would take place at specific intervals. They also said they completed competency checks in medication administration; the training record was not up to date regarding the staff that had completed a medication competency check. This was mentioned to the registered manager to address. Some staff reported they had completed moving and handling training, which included the use of hoists. However, people who used the service had different types of hoists and staff said not all sling types were covered in the training. Some staff also told us they would benefit from additional training, which covered people's specific physical and mental health needs; some people who used the service had complex needs associated with their mental health. There had been some concerns raised by relatives about staff practice and attitudes; the registered manager told us additional training had been organised to address these issues.

Although staff had received medication training, there continued to be errors made in the administration of medicines, which the registered manager said was followed up with competency checks and supervision meetings.

There were shortfalls in formal staff supervision. In the information received from 14 staff, three were aware of the supervision process and stated they had received one meeting. Other staff referred to being quite new so were not sure when a supervision meeting would take place. Other staff mentioned they had worked for the service for several months, but had not had a supervision meeting. Others said they worked nights so did

not see management. We asked to see information about formal supervision but this was not available. The registered manager confirmed a structured and proactive supervision system had been not been fully organised and conversations occurred with staff as a reaction to issues such as errors in administration of medicines.

We recommend ensuring the electronic training record is kept up-to-date and a system of formal staff supervision is put in place to ensure a more structured approach to staff development.

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

Improvements were needed in the way information was recorded in relation to how people's capacity was assessed and consent recorded for everyday tasks. These included agreement to their care plan, having bed rails or coded key locks. Information within care plans did not always detail how people who had been assessed as lacking capacity may be affected in their decision-making processes. Consent to care and support was not always recorded within people's care records. The registered manager told us some relatives had Power of Attorney (PoA) and could make decisions on their behalf. However, it was unclear the scope of these powers and whether they referred to finances only, or both finances and health and welfare. Copies of the PoA were not held with care records.

There was evidence that an assessment of capacity and best interest meetings had been held with relevant people and professionals for decisions regarding tenancy at Redwood Glades for some people. The registered manager told us most people had capacity to consent to their care and ensured care plans were discussed with people and signed by them when they were able.

We recommend that the provider seeks advice on best practice, to assess people's capacity in relation to specific decisions for people living in their own homes.

Every person spoken with confirmed staff asked their consent prior to carrying out care tasks. One person said, "Yes, it's important to talk. They ask me what can they help me with and I will say 'can you do this or that' and they do."

When staff were required to support people with their nutritional intake, this was recorded on the tasks sheet, although the information was basic. Some staff supported people to access the café on the premises for lunch or evening meals and others had support to prepare meals in their flats. Staff monitored people's weight and contacted health professionals when appropriate.

Health and social care professionals told us staff had been responsive to people's changing needs and they had updated them when required. Comments included, "We have had a few patients deteriorate and carers have been quick to add extra calls throughout the day or night. If they have concerns about people on our caseload we get messages about this or they speak to us when we are in the building."

Staff supported people to contact their GP or emergency services when required. People had relatives available to support them to attend appointments.

Each person who received a service had an individual record of the care and support provided. Any

identified concerns were recorded or reported to the senior staff for further advice and action. Examples of this included people appearing unwell, medication issues and concerns regarding people's food and fluid intake. Where appropriate, staff recorded people's behaviour that could be challenging to others.

Requires Improvement

Is the service caring?

Our findings

When we spoke with people about the staff team and the care they received, there were mixed comments. Some comments described the staff as kind and caring whilst others reported that staff approach, and at times attitude, could be improved.

Comments from people who used the service included, "It [the service] is sometimes good, sometimes okay and sometimes not so good", "There are one or two nice ones and some lovely ones", "I think the carers should have a little more time to talk to you; I do get upset as it could be so lovely here", "Yes, they are kind", "Yes, most of the staff are really nice; we have a laugh", "The staff are calm, courteous and polite" and "I think the service is brilliant."

Relatives said, "The regular carers are brilliant and have built up a great relationship with [Name]", "I could do better and I'm not a carer; they just come in and do their job" and "One [care worker] was curt with them, I did mention it, but not straight away."

Health and social care professionals said, "All the staff we have met or spoken to about patients seem very friendly, approachable and helpful", "I have come across some excellent staff attitudes but also some poor ones" and "I know their parents have praised the care staff."

Some people who used the service and their relatives were concerned about the level of communication from staff. For example, one member of staff called a relative on two occasions to say their father had fallen. The relative told us their father was deceased, so the call was upsetting, and it was another service user who had fallen. Staff had also written in their relative's notes that another relative had visited, but this was inaccurate.

People who used the service told us they were not always contacted if staff were going to be late. They said, "Sometimes they come early and sometimes they can be half an hour or an hour late", "I feel let down; the carers are good, but the communication is bad" and "They never arrive on time; if somebody different is coming, you don't get to know. One member of staff is good and they tell me when they are off and due back."

Staff were clear about how they maintained privacy and dignity, but there had been occasions when this could be improved. People told us staff did not always knock on their front doors, but used the key in the safe to let themselves in and shout 'it's only me'. One relative described a situation when their family member required their night clothes changing. They contacted the staff on duty, who explained they were busy on other calls and asked why they could not change their family member themselves. The relative said this was difficult for them as they had never witnessed their parent in an undressed state, but felt compelled to change them as staff stated they would be quite a while before they could attend to the person. The relative said it was the way staff had spoken to them that caused upset. The registered manager told us they would address this with staff now they have been made aware.

People and their relatives also commented that there had been lots of different care workers rather than having a consistent team. This had the potential to cause embarrassment for people. One person who used the service said, "Not really, no they don't [promote privacy and dignity]", whilst others said, "Yes, very good. If other people are around they would ask me if it was okay to help or did we need some privacy." Another person told us they had been asked what gender of carer they preferred and for two months their preference was not available; in the meantime a relative supported them with showering. The person said, "You get a lot of different carers; I found it really, really stressful."

Relatives told us that when they went to speak with the registered manager about issues, these were discussed in the main office, which did not afford them privacy. They also stated they often overheard conversations when the office door was open. The registered manager said a private room was available if requested and they would ensure people were made aware of this. They also told us another office had been allocated and this would address the issue of privacy when people or their relatives wished to speak in private.

When asked if visiting professionals had witnessed staff respecting privacy and dignity, they said, "Yes, they do. I have witnessed them asking patients if they would like a shower that day and what they want to eat or drink", "I have observed staff promoting dignity" and "I think care staff are too quick to enter a person's apartment when they don't come to the door [straight away] and should only do this in an emergency."

When asked if staff supported people to maintain their independence, social care professionals said, "I would say that more should be done to enable people to be more independent, that is instead of 'doing for' they should be 'enabling and assisting'. We write this in our care plans but I don't see this has been transferred into Hales care plans" and "I have not seen staff promoting independence as my client has been de-skilled in daily living tasks."

We discussed all the above concerns with the unit manager and registered manager during feedback, especially around staff attitudes and practice. They were aware of the concerns, having received complaints from people or their relatives and had arranged additional training for staff.

We recommend this training is completed quickly and regular discussions or surveys undertaken to check improvements are made.

People's care plans and medication records were held in their own home. All staff personnel files were held securely in the main office. Computers were password protected to ensure only appropriate staff had access. We saw memos from senior management to the registered manager reminding them of the need to protect personal data and points to consider when assessing data protection within the service.

Requires Improvement

Is the service responsive?

Our findings

Before people moved in to Redwood Glades, they had an assessment of their needs completed by local authority social work staff. There was also information provided to a panel, which assessed whether people met the criteria for extra care support. The local authority told us the assessment, 'My Life, My Way' was sent to the service once a tenancy had been agreed. The 'My Life, My Way' information was designed to enable staff to complete risk assessments, check if the person's needs had changed and to devise a care plan with them to meet their needs.

The registered manager told us that on occasions, the 'My Life, My Way' document did not arrive in a timely way. They said this left staff with little time to prepare the risk assessments and care plan before the person arrived at the service, which meant care plans were rushed. However, it was the registered manager's responsibility to ensure all documents were in place before agreeing to provide care and support to people. We found that some risk areas had been identified, but the records failed to show that measures were in place to minimise the risk.

The care plan records or task sheets were in place for everyone, but they were very basic and did not guide staff sufficiently in how to meet people's needs when carrying out care and support tasks. For example, one person had recommendations from a speech and language therapist regarding the texture of meals and fluids, but this information was not included in care plans. By the second day of the inspection, a new support plan had been produced, which provided more information for staff; this should have been in place straight away. Another person had a catheter in place, but the only guidance for staff stated they had to empty the catheter bag and to attach a night bag. There was no information about personal hygiene, positioning of tubing when the person was in bed or in a chair, monitoring urine output, or what to do if there were concerns. Another person had information in their 'My Life, My Way' regarding their physical and specific mental health needs, but these were not included in risk assessments and care plans. Records maintained showed not all care plans were regularly reviewed and updated.

Staff told us care plans did not always include full information to guide them in how to meet people's needs. They said, "The care plans don't have a lot of information and all say near enough the same thing", "No, not always [receive enough information about people]; we get to know people from becoming familiar with our run [care call schedule]" and "Care plans have minimal information."

The registered manager told us they would review the risk assessments and care plans to make sure they included more comprehensive information.

Thirty-two out of 79 staff had received training on end of life care and the provider had a policy in place to ensure people could be supported in line with their preferences. The care plans we reviewed did not contain information about people's preferences or arrangements for their end of life care.

The shortfall in comprehensive risk assessments and care plans was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see

what action we have told the provider to take at the back of this report.

Most people were happy and said care was provided in ways they preferred. However, there were instances when people's preferences had not been adhered to. For example, one person told us they had breathing difficulties and the smell of cigarette smoke irritated this. They continued to smell cigarette smoke on care staff despite requests for non-smoking staff. Another person's requests for gender-specific care staff had not been addressed, and had affected their care support plan. One person told us how unhappy they were that, one morning, staff were unable to use an electric tin opener or cook eggs in a microwave so they could not have their preferred breakfast. Comments included, "They're [care workers] are all different and there's no consistency. They have started to send one person more often." Another person said, "Always they will say, 'right we are supposed to do this – what else would you like us to do'."

Relatives we spoke with had mixed comments about staff responsiveness. A relative of one person told us staff did not follow specific wishes regarding little, but important, things related to food preparation. Another told us they had input into their family members care plan and it was followed consistently. Another confirmed they were invited to reviews and felt included and involved in their relatives care.

Some people we spoke with were not happy with the call times. Comments included, "If you are going out for an appointment, they don't alter times and it is just missed; they are not accommodating. Staff will apologise when they are late, but the office doesn't let us know", "I've no idea what time they are coming at lunch and tea time. You don't know when to expect the care calls; I had a review, but nothing changed", "They normally arrive on time, but are sometimes late for tea calls; they don't contact us if they are going to be late", "They do stay for the full time, but don't let me know if it's a different carer." One person said staff did not read their care plans and they were not updated.

The registered manager told us they were aware of most of the issues above and were continuing to review people's care with them to make sure that, where possible, people received their calls at their preferred times. The registered manager had, at times, been responsive to specific requests to change care workers, either at the request of people or their relatives, or due to issues such as staff having pet allergies.

The provider had a complaints policy and procedure, which was given to people when they started to use the service. The registered manager maintained a log of complaints which showed how these were addressed. Complaints were written on specific forms, people were sent acknowledgement letters and there was action following the investigation. For example, meetings were held with the complainant and supervision was completed with staff.

People told us they felt able to complain. Comments included, "I know the manager is [Name of registered manager] and I think they would deal with it if I had a complaint" and "You just go downstairs don't you to see the staff." The registered manager told us the unit manager ran a weekly drop in session for people who used the service and relatives in a confidential room in the complex to allow individuals to discuss concerns or complaints.

Requires Improvement

Is the service well-led?

Our findings

At the time of the inspection, the management of Redwood Glades was undergoing change. The registered manager had been sharing their time across another of the provider's services. The unit manager of Redwood Glades had started the process of registration with the Care Quality Commission (CQC) to become the registered manager. The current registered manager was to become a regional manager. This change meant there would be a registered manager at Redwood Glades on a permanent basis. There were team leaders present in Redwood Glades day and night for emergency situations.

There was a quality monitoring system but most audits had ceased in October 2017 in order for the unit manager to concentrate on people being admitted as tenants to Redwood Glades. The focus had been on day to day support to people and not quality monitoring, which would have enabled learning from incidents and drive improvements. There had been some audits completed on medication administration, but this was a reaction to complaints about medicines management. The lack of proactive quality monitoring had impacted on the completeness of records such as care plans and risk assessments, which were basic and did not provide full guidance to staff in how to support people. There had also been a shortfall in staff training and supervision records. There were no comprehensive audits completed with action plans to address shortfalls. We saw an action plan dated 'January/April 2018' which addressed issues of concern regarding communication and medicines management.

The last monthly internal management and compliance audit was completed in October 2017. Whilst it was good that this had identified areas of concern, there was no action plan. As the audit had not been repeated since, it was difficult to check if improvements had been made. The unit manager told us they were due to restart the monthly management and compliance audit in April 2018 now admissions had settled.

There had been a survey of people who used the service in October 2017 with 15 respondents. Most answers were positive about the service, but one person had indicated they could not communicate concerns effectively to the office staff or others involved in their care. There was no evidence that this had been addressed with the person. There was also an audit of 50 daily logs in January 2018 where people were asked specific questions about their care and support. These raised some concerns and there was a brief action plan to address them, which included spot checks and monitoring of staff practice and communication logs. The audit was repeated in February 2018. This highlighted some improvements, but there were still areas of concern regarding the approachability of office staff and whether people felt cared for with their privacy respected.

The systems in place to audit records, complete spot checks and monitor supervision and training required further work to ensure these were robust and identified the concerns we had during the inspection. The Quality Assurance system had not been fully embedded into practice. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of this report.

Despite the shortfalls in quality monitoring, the registered manager and unit manager were open and

honest about the issues they faced and were committed to making good progress to improve the quality of the service.

The registered manager and unit manager told us the provider had a structure of support within the organisation. A senior manager had attended a meeting to discuss the service in January 2018. They also confirmed senior managers were available by phone when required. They said the culture of the organisation was open and supportive, and they felt able to raise issues; the registered manager attended operational management meetings.

Staff were clear about the values of supporting people to remain independent for as long as possible. They were aware they could raise issues with senior managers. There were incentives to assist with staff retention such as a monthly care worker 'draw' with a monetary prize, a discount card for certain retail outlets, vouchers for child care and a car lease scheme.

Some staff told us communication was not as good as expected and could be improved. Team leaders told us they received shift handovers, but care workers did not. Some staff referred to raising issues with management or team leaders but these were not addressed straight away. Comments included, "Staff morale has good and bad days", "I have been well-supported", "[Unit manager's name has been very supportive throughout]" and "I love working here; it's really relaxed."

There had been three team meetings since the start of the service in October 2017. Two were in November 2017, one for team leaders and the other for care staff. There was another meeting for care staff in January 2018; these were completed to exchange information and discuss issues. Staff signed to confirm they had attended and had seen the minutes. There was also a system of sending staff memos to remind them of good practice. People who used the service also mentioned the need for an improvement in communication between them and office staff especially around changes in care worker or times of call visits.

People who used the service were unsure who the registered manager was as they were not based at Redwood Glades. Some mentioned the unit manager by name and said they would speak either to them or the team leaders if they had concerns.

The registered manager had developed relationships with other agencies and professionals involved in assessing and supporting people who received the extra care service at Redwood Glades. The registered manager and unit manager had been meeting on a weekly basis with members of the local authority and the housing provider. The meetings were to discuss new tenant applications and to ensure admissions were planned appropriately with packages of care arranged. The registered manager told us there had been some initial problems with obtaining up-to-date information about people's needs in a timely way and the notice period of admissions was very short, which had impacted on staff recruitment. However, they felt this was much improved and specific local authority staff had been very supportive. Now the service was full, they were hopeful of a more settled period where people's assessment and care planning information could be consolidated.

The registered manager told us most people who moved to Redwood Glades had to change their GP so staff had to support if there were no family members to assist; this meant facilitating an initial appointment with their new GP and also the changeover of medicines arrangements.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons had not ensured medicines were administered accurately and in accordance with the prescriber's instructions. The registered persons had not consistently ensured risks were identified and mitigated in relation to the health and safety of service users receiving care.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons had not always ensured there was an effective system of governance and quality monitoring in place. There were shortfalls in recording systems. The registered persons had not consistently ensured complete and contemporaneous records were maintained.