Anchor Trust

Anchor Integrated Care & Housing Village - Denham Garden Village

Inspection report

Denham Green Lane
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Uxbridge
Middlesex
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Website: www.anchor.org.uk

Date of inspection visit:
01 December 2016
02 December 2016

Date of publication:
07 March 2017

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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

At the time of the inspection, there was no 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. However, the registered manager had resigned, not cancelled their registration with us and a new service manager had commenced. We pointed this out at the inspection and the provider took action immediately after to ensure they complied with the conditions of their registration. In October 2016, the service manager had applied to become the registered manager and the application was in progress with our registration team.

At the time of the inspection, 24 people used the service and there were 10 staff. People received calls in their homes at set times throughout the day. At the time of the inspection, the service did not operate 24 hours a day. However people, relatives or healthcare professionals could contact the village concierge anytime to receive support. The service had plans in place to change the service to be operating all hours of the day and night.

People were protected against abuse or neglect. We heard various comments such as, "Quite safe, I would speak to the manager if I did not feel safe with staff" and "Absolutely, I can stand up for myself and will report it to the manager. I have not any experience of that (abuse),"

There were sufficient staff to meet people's needs and the service appropriately determined correct staff deployment. Feedback from people and relatives indicated that staff were rarely late to calls but people told us they were not concerned. When we checked care records, delays in calls were minimal or did not exist. We have made a recommendation that the service seek current guidance on implementing methods for monitoring late or missed calls.

Recruitment and selection of new staff members was not always robust and therefore did not ensure safety for people who used the service. Some documents and checks required by the applicable regulation were unable to be evidenced at the inspection. We have made a recommendation that the service follow best practice in relation to recruitment in the sector.

People's medicines were administered, stored and disposed of appropriately. However staff did not have completed competency assessments to document their safe ability to manage people's medicines. The service also needed to ensure that they followed the provider's medicines procedures, and used the appropriate documents. We have made a recommendation that the service ensures it's local medicine policy is updated and followed to reflect best practise and be fit for purpose.

We found staff received improved induction, training and supervision. The service utilised Skills for Care's 'Care Certificate' for new care workers and there was evidence that this was completed. More effort was required with the commencement and completion of staff performance appraisals. We made a

recommendation that the service implements a better method of collating information about staff development.

We found consent was gained before care was commenced and people's right to refuse care was respected by care workers. The homecare coordinator checked that people's lasting power of attorney details documented and a copy was on file.

People were positive about the caring nature of staff. Comments included, "Apart from looking after the way they (Staff) should, they (Staff) show concern and interest in me. We have a laugh and a chat. Carers are just nice" and "Carers are like a family and individually caring." People received care and support from staff who had got to know them well and told us their privacy and dignity was respected. We found people were supported to exercise choice and where possible encouraged to be independent.

People said the service was responsive as the care delivered centred was centred on their needs and wishes. They said if they had any concerns about the service they would report it to the manager and confirmed they were given information on how to make a complaint. There were a wide variety of scheduled activities designed to meet people's social needs and prevent social isolation.

We found significant improvements had been made since our last visit but further improvements were required. We have recommended the service seek advice and guidance in relation on how to audit recruitment records; monitor and analyse calls and keep staff updated with relevant with policies and procedures.

People were very complementary about the changes the new manager had made since joining the service. They told us there was a "marked difference" since their arrival. The service made improvements and changes to work practices as a result of feedback received from people and staff.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's medicines were not always safely managed.

Recruitment procedures were not always robust.

People were protected from abuse or neglect.

The service adequately assessed and mitigated risks to people.

The service deployed satisfactory numbers of staff.

Is the service effective?

Good

The service was effective.

There was appropriate staff training and supervision. Increased staff appraisals were required.

People's consent for care was obtained in accordance with the Mental Capacity Act 2005.

People were supported to maintain a healthy balanced diet.

People were supported to have access to healthcare services and receive on-going support from community professionals.

Is the service caring?

Good

The service was caring.

People were positive about the caring nature of staff.

People said staff treated them with dignity and respect.

People received care and support from staff who had got to know them well.

People were supported to exercise choice and where possible encouraged to be independent.

Is the service responsive?

Good

The service was responsive.

People said the service was responsive as the care delivered was centred on their needs and wishes.

People knew how to raise a complaint and were given information on how to do so.

The service had a wide variety of scheduled activities to meet people's social needs and prevent social isolation.

Is the service well-led?

Requires Improvement

The service was not always well-led.

We found significant improvements had been made since our last visit but further improvements were required.

People were very complementary about the changes the new manager had made since joining the service.

The service made improvements and changes to work practices as a result of feedback received from people and staff.

Anchor Integrated Care & Housing Village - Denham Garden Village

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.

The inspection was undertaken by two adult social care inspectors, took place on 1 December and 2 December 2016 and was announced. The provider was given 48 hours' notice because the location provided personal care in the community and we needed to be sure that staff and managers would be present in the office.

Our previous inspection in July 2015 found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the service was rated 'requires improvement'. At this inspection, we checked whether the service had achieved compliance with the associated regulations.

For this inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we already held about the service. This included statutory notifications we had received. A notification is information about important events which the service is required to send us by law. We also looked at feedback we received from members of the public leading up to the inspection.

At the inspection, we spoke with the district manager, care and dementia advisor, service manager, homecare coordinator and three care workers. We visited two people's homes as part of this inspection and

spoke to a relative.

We looked at eight sets of records related to people's individual care needs. These included support plans, risk assessments, medicines administration records (MARs) and daily care worker notes. We also looked at three staff personnel files and records associated with the management of the service, including quality audits.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in July 2015, we rated this key question 'requires improvement'. Although no breaches of regulations were found for this key question at the time, the service needed to make improvements to ensure people were always safe. This key question remains rated as 'requires improvement'.

The service was located within an integrated village that accommodated hundreds of people. At the time of the inspection, 24 people used the service. The decision to commence a care package was made by the person who used the service, but more often by relatives. The service used paper-based documents to record when calls commenced and ended. Approximately three months of records were kept in the person's apartment, after which documents were archived in the service's office. We checked the sets of the notes for staff visits to people. We found calls were on time, and rarely late. The service manager and homecare coordinator told us there were no missed calls. This could not be easily determined as checks were not routinely performed of the records.

We recommend that the service implements a method for monitoring late and missed calls to ensure continued safe deployment of staff.

Since our last inspection, we found robust recruitment procedures were not always followed. The provider had a recruitment policy dated January 2016 which set out interview and selection process for new staff. Brief reference was made to checking new staff's conduct in prior work before commencement at the service. The policy did not make reference to the relevant regulation or personnel file requirements. We looked at three personnel files of care workers. We found personnel files were disorganised and difficult to find the necessary information for inspection. The service manager and homecare coordinator needed to contact the provider's human resources more than once to obtain some of the necessary documents which were not in the personnel files at the time of the inspection.

People were not always protected because the service could not always demonstrate that fit and proper staff were employed. The service and provider could not show satisfactory evidence of new workers' employment histories, explanations for gaps in employment and confirmation of why they had left previous similar roles. We found the provider did obtain staff criminal history checks via the Disclosure and Barring Service (DBS), however for one staff member required evidence was not available. Satisfactory proof of new staff's identity was in the personnel files and the service recorded staff's right to work in the UK.

We recommend the service follow best practice in relation to recruitment in the sector.

At our previous inspection in July 2015, we stated people's medicines were not always safely managed. At this inspection, we again checked whether medicines were safely administered. Medicines were stored in people's homes. We found some people used blister packs for their medicines, whilst others used boxes and bottles. Most people ordered their own medicines, and only a limited number required assistance from staff to ensure continuity of supplies. During administration, medicines were given according to the medicines

administration record (MAR). We viewed examples of prior MARs and found no missed signatures or gaps in administration. The homecare coordinator had implemented a robust system for documentation of medicines. There was a 'my medication profile' and a copy of the MAR chart for each person. Each month, and following GP or hospital visits, the homecare coordinator checked the accuracy of medicines the person took was checked and corroborated. Where changes were found, the care documentation was updated to reflect this. The homecare coordinator had also organised staff training in the administration of eye drops. This ensured care workers could administer more types of medicines for people. The homecare coordinator planned to organise staff training for how to apply medicines patches to people's skin.

The provider had two medicines policies dated August 2016. One was specific to the type of service but changes were not made to ensure it was suitable for the local people who used the service. The policies were brief and did not cover all topics associated with medicines safety. For example, crushing of medicines and swallowing difficulties were not included. However, the provider's policy contained a number of good subsidiary tools to ensure safety of medicines management. We found the provider's systems were not always followed by Anchor Integrated Care & Housing Village - Denham Garden Village.

Staff completed training in medicines safety. Staff training included the theory of medicines administration, at three levels. We saw from electronic records that staff had completed their medicines theory training appropriately. Supervised administration of medicines was completed by new staff during the first four days of 'shadowing' an experienced staff member. However, the service did not record new staff members' observed ability to safely administer medicines. This was not in line with the provider's policy. A medicines competency tool was available but no staff member at the service had a completed one on file. An experienced staff member was required to document observed medicines administration for all new workers. In addition, other tools required by the provider's policy were not utilised. This included 'when required' medicines protocols and warfarin administration records provided by the preferred pharmacy. We brought this to the attention of the service manager and homecare coordinator. They were not aware that the tools existed, but explained these would be implemented to further ensure people's medicines management by staff was safer.

We recommend the service's local medicine policy be updated and followed to reflect best practise and be fit for purpose.

People said they felt safe from abuse. Comments included, "Quite safe, I would speak to the manager if I did not feel safe with staff" and "Absolutely, I can stand up fo myself and will report it to the manager. I have not any experience of that (abuse),"

We spoke with one relative who said that their family member received safe care. They told us they felt that staff ensured the safety of the person who used the service at each visit. The relative said, "If there are any problems, they will sort them out." At one point, the relative had also used the service temporarily during recovery from surgery. The relative told us that their 'faith' in the safety of care was demonstrated when they were the person who used the service.

People were protected because systems were in place to prevent abuse and neglect. There was signage available in the office for staff, about both safeguarding people and whistleblowing. We found the provider had appropriate policies for safeguarding and staff whistleblowing, and these were current. The provider's policies were in accordance with the Care Act 2014. The service also had access to a copy of the local authority's safeguarding adults procedures, which contained the necessary information about dealing with and reporting abuse or neglect. The service manager and homecare coordinator were clear about their part in managing safeguarding concerns. This showed the service was aware of procedures to protect people. We

saw care worker inductions and training included safeguarding. Staff training about safeguarding vulnerable adults was robust, as there was the requirement to complete an electronic learning course as well as updates to refresh their knowledge. The service reported safeguarding allegations to the local authority and us, in line with procedure and regulations.

People were satisfactorily protected from risks. We found the service assessed and managed people's risks of personal care. An internal service audit from March 2016 suggested that additional information was required for people's risk assessments. The service had an action plan and had implemented improvements to risk assessments. We found care documents contained satisfactory risk assessments and management plans to mitigate the identified risks. We looked at six care records for people who used the service. In the risk assessments and care plans we examined, we saw a comprehensive range of documents pertaining to risks. Examples of risks recorded included environmental hazards in people's homes, moving and handling, falls, medicines administration and nutrition and hydration. People also had the ability to summon help via call bells in their apartments and pendants worn like a lanyard. These were responded to by a 24 hour onsite concierge. Where necessary, service management were called or medical help obtained. People could also telephone the concierge staff from their apartment for assistance. The service was in the process of implementing night shift care workers. This was in response to feedback from people who used the service that had expressed the need for night staff. This was a positive step to ensure people were safe around the clock.

The service ensured that people were protected from risks associated with their care and documented when harm occurred. Staff documented incidents or accidents to people when they occurred. Since the last inspection, there were a limited number of incidents or accidents reported. We found the service used an electronic system, but paper-based forms were also available. We viewed the reporting system and how it operated. It was a simple method for a care worker or a manager to quickly record details of all types of incidents. We found once submitted, incident reports were reviewed by the service manager. In addition, any incidents reported were also viewed at an area and organisation level. This ensured any trends or patterns in incidents could be monitored effectively. If risks to people were identified in an incident report, we were told that necessary changes would be made to their care. An appropriate business continuity plan was also in place, to ensure people still received care, for example in severe weather.

We found that the service deployed sufficient staff to ensure people's needs were met. The service manager told us that staffing deployment was matched to people's needs. In the initial assessment before care packages commenced, people's dependency was determined to understand the number of staff required for calls. Where the person required hoisting because of their mobility, this was always completed with two care workers present. We were told that people's calls ranged from a 15 minute call on weekdays, through to 4 calls every day of the week. The number and length of calls depended on the person's dependence for care. We found the provider had some flexibility in their workforce. Staff that worked for the service would complete additional visits, when needed. There was no use of agency staff at the service. People and relatives told us that their personal care calls were on time. They told us they would call the office if a care worker was late. The homecare coordinator also explained that where a care worker was reported as delayed, they would call people scheduled for their visit to advise of possible late calls.

Good

Is the service effective?

Our findings

At our previous inspection in July 2015, we rated this key question 'requires improvement'. We found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff were not properly supported and monitored and had not received appropriate supervision. We also found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because changes to people's needs were not adequately monitored or recorded. We issued two requirements to the service. A service delivery manager submitted an action plan to us on 28 August 2015. At this inspection we checked whether the service had achieved compliance with Regulation 17 and Regulation 18 after proposed improvements.

The provider used a standardised process for staff supervisions. There was a one-page form which required completion by the staff member, a discussion with their line manager, and recorded signatures of both parties. The form did not allow the staff member's line manager to record any comments of the supervision meeting. We pointed this out to the service manager who took note of our finding. The service did not have a single centralised record of the dates or number of supervision sessions each staff member received since the last inspection. At the inspection, the service manager and district manager were required to check each staff member's personnel files for the details. We were provided with the number of supervisions that each staff member participated in since the last inspection. This was generally between six and seven meetings with their line managers, excluding new care workers. We found staff received appropriate supervision sessions with the service manager or other senior staff member.

Staff were required to set objectives each year and have performance reviews. When we checked records, we found that some staff had completed this. The provider had changed the type of forms that staff used to record their performance reviews in. This made it difficult to determine at the time of the inspection whether enough staff had successfully commenced or completed performance reviews. We wrote to the service manager following the inspection. We received information from the service, including dates, that staff completed supervision sessions and commenced or completed performance reviews. According to the records, two experienced staff had not commenced or completed performance reviews. We found however that appropriate staff supervision and appraisals had increased since the last inspection. We found that the service was compliant with Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We recommend that the service keeps accurate records of staff supervisions and appraisals, and adheres to a continuous cycle of staff development.

People received care from staff who had the knowledge and skills to carry out their roles and responsibilities. Comments from people included, "They are very competent, it's interesting how a new carer comes in but after a couple of visits they know my routine" and "I would say they do know what they are doing."

We found that there was an improvement in staff training. Evidence was stored in staff personnel files as well

as a new online 'training tracker'. We saw new care workers received induction, support and a mentor to establish knowledge and skills to carry out their role. Care workers attended induction on site. After this, care workers shadowed another experienced care worker for at least four days of people's visits, depending on their prior experience working in adult social care. The service manager or homecare coordinator then conducted a competency check of the care worker to ensure they could effectively complete personal care. The service manager or homecare coordinator also completed unannounced 'spot checks' of the care worker to ascertain their effectiveness of providing people's care.

We found appropriate subjects related to being a care worker were covered during induction. The service used industry-wide training methods for adult social care staff, such as Skills for Care's 'Care Certificate'. New care workers were required to undertake the required 'Care Certificate' to ensure they were able to carry out their roles and responsibilities. We saw one care worker had successfully completed the entire Care Certificate after their induction, and another new staff member was in progress of completion. The service recorded staff training in a database which showed the due date for it to be completed and the date it was completed. Staff completed on-going training throughout their employment at the service. Topics included manual handling, infection control, health and safety and safeguarding people at risk. We found staff had completed or were in the process of completing formal qualifications in health and social care.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

At the time of the inspection, the service worked in line the requirements set by the MCA and the associated Codes of Practice. We found consent was always legally gained for people's care. We saw consent was obtained from people who had satisfactory mental capacity to make the decision themselves at the time. Staff told us they always assumed people had the capacity to make decisions for themselves, unless they had proven otherwise. There was a risk however, that the service could ask relatives or 'next of kin' instead for agreement or signatures on consent forms. This risk was reduced by the homecare coordinator who had clear oversight of people's ability to consent and lasting power of attorneys (LPAs). The homecare coordinator had obtained copies of the documents for a small number of people who already had LPAs. The provider's corporate care forms contained multiple areas where consent or attorney information required documentation by staff. Where there was no one who could legally consent for a person, the provider had a robust best interest decision-making policy, process and associated tools in place. We found the service manager and homecare coordinator understood the MCA, consent process and best interest decision making. Staff received training about the MCA during induction and refresher training on a repeated basis.

We found that the service was compliant with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Each person who used the service had a 'key worker'. The 'key worker' was a named staff member responsible for the overall care package of the person and required to check care documentation was complete. The service had implemented appropriate systems of communication about any changes in people's personal care. This meant the service could effectively monitor changes in people's needs in the event of the service manager's or homecare coordinator's absence. Changes included increased auditing of care documentation to find gaps or omissions and

increased regularity of communication between the staff team to handover any changes. Where changes were identified, we saw these resulted in changes to risk assessments, care plans and the care provided to the person. We checked three people's daily notes from care visits. The notes were person-centred, specific and detailed whether the care was different to that previously planned.

People were supported to have sufficient to eat and drink and maintain a balanced diet. Due to the unique location of people related to the service, there was close access to a café, restaurant, pub and small shop. People could come from their apartments to access these amenities; where necessary with staff assistance. Organised transport also meant people could go to other locations to obtain necessary food or drinks. A limited number of people who used the service received support with grocery shopping, the preparation of their meals or eating and drinking. Where necessary, the person was encouraged to be as independent as possible in heating or cooking and eating their meals. People's records contained assessment forms about eating and drinking. Where necessary, entries in care notes were recorded about what people had to eat and drink. We viewed examples of the daily notes and found these were appropriate. Staff told us they would call health professionals if people at risk with existing health conditions did not consume sufficient food. This ensured the risk of malnutrition over time was reduced for the person. We saw people's preferences for meals were recorded in the care folders.

A GP surgery was available within the centre of the village. Although people could choose their own GP, many were registered with the nearby village GP. People who used the service at the time of the inspection were mostly independent. However, we saw people were reminded or supported by the service to attend all necessary medical and healthcare appointments away from their own homes. Examples of good support to people related to healthcare included assistance with GP visits, dentists and opticians. The staff told us they could assist to make referrals to necessary healthcare professionals as required.

Good

Is the service caring?

Our findings

People were positive about the caring nature of staff. Comments included, "Apart from looking after the way they (Staff) should, they (Staff) show concern and interest in me. We have a laugh and a chat. Carers are just nice" and "Carers are like a family and individually caring."

People received care and support from staff who had got to know them well. Staff confidently described people's care needs; family relationships and preferences. The care records of the people staff referred to captured their fond memories; family and childhood histories; working life; life events; significant places and significant people. We found this confirmed what staff had told us. This enabled positive and caring relationships to be developed with people who used the service.

People had their privacy and dignity respected. When giving an example of this one person spoke about how a staff member who supported them with personal care, ensured they were "Wrapped in their towel" and their door was kept shut. The person mentioned that a maintenance worker had been visiting their home at that time and the staff member offered to remain with them until the maintenance worker had left. Another person commented, "They (Staff) make sure its very private when washing me. I can shut my front door and be utterly private. They treat me in a restful way." Staff told us how they ensured people's dignity. We found this to be in line with the 'Dignity Policy' which stated people should be treated as individuals, have their views listened to and respected.

People said they were involved in planning their care. This was confirmed by the people we spoke with. For instance one person commented, "I am always involved." This was evident in care records that captured people or their representative's views and expectations in regards to their care and support needs. For instance, we noted people had signed to confirm they had been involved in their assessment of needs and wishes and had made the decision to be supported with all their care and treatment needs. This meant people were enabled to express their views and be involved in decisions that concerned their care.

People were supported to exercise choice and where possible encouraged to be independent. Staff said they offered people choice from what they want to eat to what clothes they want to wear. One staff commented, "Everything is a choice whether people want me to open the curtain to whether they want tea or coffee." People were supported to maintain their independence. One person commented, "I am determined to do as much as I can." We noted this was recorded in the person's care record. The person said that staff were aware of this and only provided care they were unable to do for themselves. A staff member who provided care and support to the person confirmed this. This meant people could be as independent as they want to be.

People and their relatives were given support when making decisions about their preferences for end of life care. This was supported by our conversations with people who told us they had discussed their end of life wishes with the service. For instance one person commented, "Yes, I have discussed it (End of life) with them (Staff). They know I don't want to be resuscitated." We saw this was clearly recorded in the person's care record. Some staff had not as yet provided care to people who were at the end staff of their lives. However

staff us they had attended the relevant training. A review of training records confirmed this. This meant people and those who represented them would receive appropriate support when they came to the end stages of their lives.

Good

Is the service responsive?

Our findings

At our previous inspection in July 2015, we rated this key question 'requires improvement'. Although no breaches of regulations were found for this key question at the time, the service needed to make improvements to ensure people received responsive care. At this inspection we checked whether the service had achieved compliance after proposed improvements.

People said they knew how to raise concerns. Comments included, "I will phone the manager. I don't have to though" and "I would ring (Name of manager) straightaway or go to higher management if I need to. I have had information on how to do this (Make a complaint)." Staff knew how to handle complaints but stated that had not had the opportunity to do this. We reviewed the service's complaint's policy which provided information on how complaints received would be handled. A review of the complaint's registered showed the service had only received one complaint. It clearly documented what the concerns were and the action taken by the service in response. We noted the complaint had been resolved to the person's satisfaction.

We found complaints were responded to and monitored to ensure improvements were made where required and reviews of care were regularly undertaken.

People's needs were reviewed regularly and as required. Reviews of care meetings enabled people and those who represented them to discuss the care and support delivered and gave them the opportunity to make any necessary changes. Reviews of care recorded the areas of care discussed and agreed actions. It was clearly noted where there was no need for changes in the care being delivered. They also clearly captured what people and their relatives had said. Staff told us reviews of care were undertaken on a monthly basis. This was supported by the people we spoke with and confirmed in the care records viewed. This meant people's needs of care were regularly reviewed for their effectiveness and were kept up to date.

People had their needs assessed before they joined the service. Information had been sought from people, their relatives and other professionals involved in their care. We noted the information from the assessment had been used to inform people's plan of care. They captured people's preferences; choices and identified any potential risks to people's health and welfare. These were signed and dated by people or those who represented them to confirm the information accurately reflected their care and support needs.

People said the service was responsive as the care delivered centred on their wishes. We heard comments such as, "I can say what I need and if I want to alter it (Their care package), it can be done. They (staff) tailor it (delivery of care) to your needs" and "It's enough for what I need."

The service was responsive to people's care and support needs. Staff knew how to put care that centred on people's needs in practice and gave examples of how they did this. Comments included, "I'm always asking them (People) what they want because sometimes what they want changes", " It's about listening and acting on what people say" and "I ensure I carry out the care identified in their care plan." This ensured people received care that reflected what they wanted.

There were a wide variety of activities on offer for people who lived in Denham Garden Village which was a large residential area with 300 properties. This included access to the village shop and bar/restaurant, hairdressers, gym, swimming pool and a nail bar. Other activities were offered to all people who lived at Denham Garden Village including arts and crafts, bridge club and walking clubs. Access to the community was well linked with a bus stop which provided a service from the main entrance of the village. At our last inspection in July 2015 the registered manager told us had intended to use a communal room at the village to provide activities specifically for people who used the services. During this visit we noted this had not yet happened. The manager showed us an area that had now been designated for that purpose. The manager informed us they had recognised there were some people who were not able to attend the group activities on offer. In order to accommodate them the service had started offering one to one activity sessions such as cake baking; shopping trips; daily walks or crossword. We saw this had been advertised on the resident's noticeboard. These meant peoples' social needs were met because the service had a scheduled program of social activity program that prevented social isolation.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in July 2015, we rated this key question 'requires improvement'. We found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because evidence was not always documented or recorded which made it difficult to run an efficient service.

We found significant improvements had been made since our last visit but further improvements were required. This was because there were no audits conducted of staff recruitment records to ensure that the required documents were available in every case. There were no systems in place to evidence the monitoring and analysis of late or missed calls. Updated policies and procedures for instance medicines policy, were not read by staff which meant correct working practices were not always being followed.

We recommend the service seek advice and guidance in relation on how to audit recruitment records; monitor and analyse calls and keep staff updated on relevant policies and procedures.

People were positive about the management of the service. Comments included, "Management are experienced and know what they are doing. I feel beautifully looked after" and "I am quite happy with them (Management). I've never had any problems."

A new manager was in place at the time our visit. We had been informed that the registered manager had resigned but noted they had not cancelled their registration with us. We pointed this out at the inspection and the provider took action immediately after to ensure they complied with the conditions of their registration. We were advised the new manager had applied to become the registered manager for the service and had submitted their application in October 2016, which was in progress with our registration team.

People were very complementary about the changes the new manager had made since joining the service. They told us there was a "marked difference" since their arrival. This was supported by staff who told us the change in management was positive. We heard various comments such as, "I am very happy with the fact I can go to see the manager with any concern", "I think (Name of manager and care co-ordinator) have the experience needed to manage the service. They have the residents' heart in mind and they're good with the carers", "Things have got better since she (Manager) had been here" and "I really appreciate the manager and teamwork I have experienced here and I want to do the best that I can to provide good care to our customers. Management are helping me to achieve this." This showed there was leadership that inspired staff to provide a quality service.

Staff felt supported by management and felt confident to raise any concerns in relation to poor work practices. They told us team meetings occurred regularly which enabled them to be kept up to date with any changes in the service, as well as be reminded of their responsibilities. A review of staff team meetings dated 3 October 2016 and 21 November 2016 confirmed this.

Management listened to staff and made changes as a result of their feedback. For instance one staff member commented, "There was a time when we couldn't have breaks. We talked to management about this and now we have set times to take a break." The manager told us in response to feedback received from a 'Customer Survey' in 2015 people said they would like to have access to care at night. We saw evidence of correspondence that had been sent out to people informing them that the service would now be offering night shifts from 5 December 2016. This meant the service made improvements and changes to work practices as a result of feedback received from people and staff.

Although quality assurance systems in place were not completely robust. We found a comprehensive system was in place to ensure improvement to the quality and safety of people's welfare. There were audits of records relating to the care and support delivered to people as well to ensure staff received up to date training. For instance, we saw a letter of from senior management that acknowledged the manager's achievement of getting all staff up to date with their training. This demonstrated the service had systems to drive continuous improvement.

The manager had identified an organisation that provided support to people who wanted to receive care and support but could not afford it. We saw evidence of referrals that had been sent to the service. This was supported by a person who told us, "The manager was instrumental in getting me attendance allowance which helped me to get the carers." This showed the service worked in partnership with other agencies to ensure people's care needs are met.

The provider carried out internal inspections that was in line with the Care Quality Commission's (CQC) methodology of rating services. We reviewed the internal inspection report for a visit that was carried out on 11 March 2016. The assessor conducted a thorough review of work practices and care records. This resulted in the service being rated as requires improvement in safe; effective; responsive and well-led. The caring domain had been inspected on this visit. The report highlighted the areas for further improvement. We viewed a comprehensive action plan that had been developed as a result of the visit and noted appropriate action had been taken and clear indication where work was still on-going. This enabled the service to identify where quality or safety was being compromised and take appropriate action.