Carewatch Care Services Limited

Carewatch (Cottesmore House)

Inspection report

Cottesmore House
Perkins Gardens, Ickenham
Uxbridge
UB10 8FT

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30 August 2018

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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

This comprehensive inspection took place on 29 and 30 August 2018 and was unannounced.

Carewatch (Cottesmore House) has been re-registered under the provider, Carewatch Care Services Limited since March 2018. The company was established in 1993, and runs a range of care services in the whole of the UK. This was the first inspection of Carewatch (Cottesmore House) under their ownership. Carewatch (Cottesmore House) is also registered to provide care and support to people living in Triscott House.

Carewatch (Cottesmore House) is an extra care housing service. 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. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

At the time of the inspection the service provided personal care to people living in two extra care settings, Cottesmore House and Triscott House. There were 42 people living at Cottesmore House, four of whom were not receiving personal care. There were 38 people living at Triscott House. Each person was living in their own flat and had their own tenancy with Paradigm Housing Association who also owned the buildings. There were eight flats on the fifth floor of Cottesmore House which were exclusively for people with a learning disability.

The part of the service for people with a learning disability has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

There was a registered manager in post at the time of our inspection. 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. There was quality officer at each of the two schemes who managed the day to day running of the service.

Staff did not always follow the procedures to manage medicines which meant that people were at risk of not receiving their medicines safely.

Not all the risks to people's wellbeing and safety had been assessed, and where risks had been identified, the provider had not always taken appropriate action to mitigate these.

The provider had systems in place to monitor the quality of the service and put action plans in place where concerns were identified. However, although an audit in May 2018 had identified some of the issues we

found in relation to risk assessments and medicines audits, the provider had not taken prompt action to address the shortfalls they had identified.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment and good governance. You can see what action we told the provider to take at the back of the full version of the report.

The provider was not always acting in accordance with the Mental Capacity Act 2005 (MCA). There were no records to show that any attempts had been made to appropriately assess a person's mental capacity in line with the MCA principles.

People did not always receive person centred care and there was little stimulation for those who were unable to go out even if this was part of their care plan. Some staff practices were not always person-centred and did not take into account people's choices.

We have made recommendations to the provider with regards to person-centred care, people's social and recreational needs and consent to care and mental capacity.

People had access to healthcare professionals where necessary and the outcomes of their visits were recorded in people's care plans for follow-up and review.

People were protected by the provider's arrangements in relation to the prevention and control of infection.

The provider had processes for the recording and investigation of incidents and accidents. These were investigated and where necessary measures put in place to prevent reoccurrence. The provider acted appropriately when things went wrong.

Care plans and risk assessments were reviewed and updated whenever people's needs changed. People told us they were involved in the planning and reviewing of their care and support and we saw evidence of this. However, we saw that one person had not signed their care plan.

Recruitment checks were carried out before staff started working for the service and included checks to ensure staff had the relevant previous experience and qualifications to work with people using the service.

Staff assessed, recorded and monitored people's health and nutritional needs and took action where necessary to make sure these were being met.

Staff liaised with the relevant healthcare professionals to provide appropriate care and support when people reached the end of their life.

People were supported by staff who were sufficiently trained and supervised. The registered manager liaised with other services to share ideas and good practice.

People's care plans were comprehensive and detailed how their individual needs were to be met. They were personalised to reflect people's wishes and what was important to them.

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.

Staff did not always follow the procedures for the management of medicines. This meant that people were at risk of not receiving their medicines safely.

Not all the risks to people's wellbeing and safety had been assessed, and where risks had been identified, the provider had not always taken appropriate action to mitigate these.

People were protected by the provider's arrangements in relation to the prevention and control of infection.

Incidents and accidents were recorded and appropriate action was taken to reduce the risk of reoccurrence.

People using the service said they felt safe when they received support.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider was not always acting in accordance with the Mental Capacity Act 2005 (MCA). There was no evidence that any attempts had been made to appropriately assess a person's mental capacity in line with the MCA principles.

People's individual needs had been assessed and recorded in their care plans prior to receiving a service, and these were regularly reviewed.

People were supported by staff who were well trained and supervised.

People's health and nutritional needs had been assessed, recorded and were being monitored. People's healthcare needs were met.

Is the service caring?

Requires Improvement

The service was not always caring.

Some staff practices were not always person-centred and did not take into account people's choices.

Notwithstanding the above feedback from people and relatives was positive about both the staff and the management team.

People and relatives said the care workers were kind, caring and respectful.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were not always met and there was little stimulation for those who were unable to go out even if this was part of their care plan.

Support plans did not always contain information about people's end of life care needs, wishes and preferences. In addition to receiving care from Carewatch (Cottesmore) care workers, people received end of life care from outreach workers and healthcare professionals.

Care plans contained enough detail for staff to know how to meet peoples' daily needs.

There was a complaints policy and procedures in place. People's concerns were addressed appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There were systems in place to assess and monitor the quality of the service, but these had not always been effective in that these had always led to improvements where issues were identified.

People and their relatives found the management team to be approachable and supportive, however, most people did not know who the registered manager was, therefore they were unsure who was responsible for the running of the service. The registered manager was taking action about this.

There were regular staff meetings and meetings with people who used the service. This promoted a culture of openness and trust within the service.

Carewatch (Cottesmore House)

Detailed findings

Background to this inspection

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

This inspection took place on 29 and 30 August 2018 and was unannounced.

The inspection was carried out by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed notifications the provider sent us. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about.

During the inspection, we observed support being delivered to people to help us understand people's experiences of using the service.

We looked at records, including 15 people's care plans, five staff records, medicines administration records and records relating to the management of the service. We spoke with 19 people who used the service, five relatives, one volunteer, the provider's head of extra care services for London, the quality improvement service manager, two quality officers also working for the provider, two senior care staff, one housing support staff and a range of care and outreach workers. The registered manager was on annual leave at the time of our inspection so we were assisted by the quality officers and the quality improvement manager. We spoke with two healthcare professionals who were visiting on the day of our inspection.

Requires Improvement

Is the service safe?

Our findings

People we spoke with indicated they felt safe in their environment and trusted the staff who supported them. Their comments included, "I get down sometimes living here but it always feels safe here", "Oh yes [I feel safe], and I can use my bell to call for assistance", "Yes, I have my buzzer and I use it if I want anything at all", "You know in your mind that you are safe. If you ring the buzzer, they will chat, they'll talk to you and ask what you want to do" and "I could be in a much worse place than living here. I am grateful."

The provider did not ensure that medicines were always managed safely. We checked the medicines administration record (MAR) charts for 12 people who used the service and saw that there were a number of discrepancies, mostly in Triscott House. For example, one person's tablets had not been signed for on two days and another tablet was missing a signature on one day, although the care notes stated that these tablets had been given We checked the boxes containing these medicines but found that there was no date of opening, and staff had not recorded the number of tablets carried forward from the previous cycle. This meant that we could not be sure if the missing signatures were an oversight or if the person had not received their prescribed medicines.

A second person was prescribed pain killers, two to be given four times a day. We saw that there were no staff signatures on two days. The MAR chart was unclear, there was no date of opening of the box, and staff did not keep a running count of these tablets. This meant that we could not be sure the person was always receiving their prescribed medicines.

Another person was prescribed a medicine to be administered as one tablet daily and 28 tablets of the medicine were supplied. We saw there were 11 staff signatures but still 18 tablets left in the pack. This meant that it was possible that staff had signed and had not given the medicine on one day. Staff were unable to offer an explanation for this.

We met with a person who appeared to be unsure about their medicines. They had all the boxes opened and told us they did not know if they had received the right medicines. We checked these and saw the MAR chart had not been signed on 12 August. Again, the number of tablets in the packs did not correspond to the number of staff signatures and staff were unable to offer an explanation for this. Although the person had capacity, they required staff support to receive their medicines. They told us they were unwell and we could not be sure they were able to handle their medicines safely. There was no risk assessment in regard to medicines.

The recorded instructions for some prescribed medicines stated, 'One or two tablets to be given'. However, staff did not record the amount administered therefore it was not possible to monitor what dose was most effective to manage the person's condition and to ascertain if the amount in the boxes corresponded to the amount administered. In addition, there were no daily audit charts of boxed medicines.

The provider had not ensured that all risks to people's safety and wellbeing had been appropriately assessed and mitigated. Staff expressed concerns about a person using the service who was living with

dementia, and who often displayed behaviours that challenged. One staff member told us, "We are not equipped to deal with dementia. We are supposed to get training" and another stated, "[Person] is currently being prevented from going out for their own safety although the place is not a care home and therefore not secure." We saw that the risk of this person going out had not been assessed and staff were unsure about how to keep the person safe. They told us they did not always know how to meet the person's needs and manage incidents. We saw that there were no systems to record and manage incidents where the person displayed behaviours that challenged, therefore, staff told us they felt "at a loss" and dealt with incidents without knowing if their actions were right or wrong. Another person's care plan indicated they were at risk of falls. However, there was no risk assessment in place and no guidelines to staff about how to prevent the person falling. We discussed these concerns with the quality officer who told us that the registered manager was in contact with the local authority and had requested for the person to be re-assessed.

The above paragraphs show that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Folllowing the inspection, the registered manager informed us that the quality officer had recently undertaken dementia training involving virtual reality and there were plans to roll out this training to care workers. They also stated that all care workers received training in dementia during their induction, and some had received specialist training in dementia through an external training provider.

We discussed the concerns we identified about the management of medicines with the quality officer and the quality improvement service manager. They took immediate action regarding the incident where the person who was unwell and confused about their medicines which included, seeking advice from the GP and pharmacist, informing the local authority's safeguarding team, and conducting an internal investigation. We were reassured that the person using the service had been under close observations and had shown no adverse effects.

At Cottesmore House, we found that medicines were managed well and there were protocols in place for the use of PRN (as required) medicines, for example, pain relief medicines. Boxed medicines were counted at each administration by staff to ensure they were correctly administered and at the right time. These checks were recorded and kept up to date. However, we found one error where one person's medicines audit sheet stated 33 tablets left but only 31 were in the pack. The quality officer undertook an immediate investigation and found that this was a recording error and the staff responsible had failed to undertake daily audits. Appropriate disciplinary action was taken immediately.

In other people's files, we saw that person-specific risk assessments and plans were available and based on individual risks that had been identified either at the point of initial assessment or during a review. These were reviewed yearly or more often if necessary and included risks to general health, mental health and the person's ability to complete tasks related to everyday living such as nutrition, personal care and mobility. Based on the level of risk, appropriate control measures were in place. For example, where a person had been identified at risk of choking, we saw a protocol for the prevention and management of choking was in place. This included information about the causes of choking and instructions for staff about how to prevent this, and how to act if the person started choking such as "Implement any taught first aid techniques" and "Call emergency services and follow their instructions."

People confirmed they would know who to contact if they had any concerns, and added they did not have any concerns about the service. Staff received training in safeguarding adults and training records confirmed this. Staff were able to tell us what they would do if they suspected someone was being abused. The service had a safeguarding policy and procedure in place and staff had access to these. Staff told us they were familiar with and had access to the whistleblowing policy. This indicated that systems were in

place to help protect people who used the service from the risk of abuse.

The provider raised alerts of incidents of potential abuse to the local authority's safeguarding team as necessary. They also notified the Care Quality Commission (CQC) as required of allegations of abuse or serious incidents. They worked with the local authority's safeguarding team to carry out the necessary investigations and management plans were developed and implemented in response to any concerns identified to support people's safety and wellbeing. Records we viewed confirmed this.

Staff were clear about how to respond in an emergency. Senior staff were available to help and support the staff and people using the service as required, and involving healthcare professionals as needed. One staff member told us, "They take our concerns seriously, definitely. They listen to me. For example, I was worried about a service user who did not look right. They took notice. I can't think of anytime where I have been ignored."

Incidents and accidents were recorded and analysed by the registered manager to identify any issues or trends. We saw evidence that incidents and accidents were responded to appropriately. This included an action plan to reduce the risk of re-occurrence and a referral to relevant healthcare and social care professionals.

The provider took appropriate steps to ensure that lessons were learned when things went wrong. For example, when they received a complaint, they communicated with staff to ensure systems were put in place to make the necessary improvements and reduce the risk of further complaints. The quality service improvement manager told us, "We make sure there is learning from everything such as incidents and accidents and complaints. We analyse what went wrong and improve our systems. We keep checking to make sure they work."

The provider had a health and safety policy in place, and staff told us they were aware of this. A general risk assessment was in place which included how the service managed risks related to medicines administration, infection control and manual handling. Equipment used in the care of people was regularly serviced to ensure it was safe, and we saw evidence of recent checks.

The provider worked with the housing department to protect people in the event of a fire, and we saw that individual risk assessments were in place. People's records contained detailed individual fire risk assessments and personal emergency evacuation plans (PEEPS). They included a summary of people's impairments and abilities, and appropriate action to be taken in the event of fire.

People were protected from the risk of infection. People were supported to maintain and clean their own flats. Staff were provided with personal protective equipment such as gloves, aprons, hand washing facilities and sanitisation gels to ensure infection was prevented and controlled. However, one person told us, "It was quite funny this morning, the shout went up that the CQC were in and that everyone should put their aprons on."

People and relatives told us they were happy with the staffing levels, and we saw that there were enough staff on duty on the day of our inspection to meet people's needs. The service employed regular staff who were on site 24 hours a day.

People living at the service had their care needs assessed before they started living at the service, so that the provider was confident people's needs could be met in the service and for people to receive individual packages of care. Some people required minimal support and others required visits up to four times a day to

support them with their personal care needs. People and their relatives told us they were happy with the amount of support they received. Everyone living at the service was issued with a call pendant, so that they could call for assistance wherever they were in the building. Most people told us staff responded to calls promptly, although one person said, "When I press my buzzer, they do generally come. The worst ever for me was a wait of about an hour."

Recruitment practices ensured staff were suitable to support people. These included checks to ensure staff had the relevant previous experience and qualifications to work in this sector. Checks were carried out before staff started working for the service. These included obtaining references from previous employers, reviewing a person's eligibility to work in the UK, checking a person's identity and ensuring a criminal record check such as a Disclosure and Barring Service (DBS) check were completed.

Requires Improvement

Is the service effective?

Our findings

We checked whether the service was working within the principles of the Mental Capacity Act (MCA) 2005, and whether any conditions on authorisations to deprive a person of their liberty were being met. The MCA provides a legal framework for making particular decisions on behalf of people who use the service and 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 to 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.

Most of the people living at the service were independent and had the capacity to make decisions about their care and support. However, for one person who lacked capacity, we saw that their support plan indicated that a mental capacity assessment had been completed, but elsewhere in the file, it said that it had not been. We discussed this with the person in charge who investigated and found that no mental capacity assessment had been completed. They told us they would address this without delay. We also noticed that the person had not signed their consent form so we could not be sure they had consented to their care and support and because they did not have a mental capacity assessment, we could not be sure they had capacity to consent to their care. There was also no record to show that any decisions had been made in the best interests of the person.

We recommend that the provider review people's consent to care and mental capacity to make decisions in line with national guidance on the Mental Capacity Act 2005

At the time of our inspection, there were concerns about a person using the service whose needs had increased due to their condition, and whose mental capacity had seemed to be decreasing. Staff reported concerns that the person was restricted from going out for their own safety. We relayed these concerns to the registered manager after our inspection. They provided evidence that the person had been assessed as having capacity at the time of their admission to the service. However, due to recent concerns, the provider had contacted the local authority to seek advice and to request a review to take place as soon as possible.

We saw in other people's care records that consent was obtained and people were involved in decisions about their care and support. This indicated that for these people care and support was being delivered according to the principles of the MCA. Staff told us they encouraged people to remain as independent as they could be. People said staff gave them the chance to make daily choices. We saw evidence of this throughout the day of our inspection.

People were supported by staff who had the appropriate skills and experience. Most of the staff had been working for the previous provider and had been subject to an induction process that included a "care

worker's assessment" where the staff member's competencies were assessed. This included manual handling, dignity and respect, personal care, medication support, safety and communication. Upon completion of the assessment, the named assessor provided feedback, and decided if the staff member was ready to work alone or if further training and support was required. In addition, staff received training the provider had identified as mandatory. This included, health and safety, first aid, moving and handling, infection control and food hygiene. They also undertook training specific to the needs of the people who used the service which included person-centred care and equality and inclusion. One staff member told us, "Training has been absolutely brilliant." However, staff told us they had not received training in dementia care and therefore, they were finding it difficult to meet the needs of a person who was living with dementia. We discussed this with the management team who told us they would seek relevant training for staff as soon as possible.

During the inspection we spoke with members of staff and looked at files to assess how they were supported within their roles. Staff told us and we saw evidence that they received regular supervision from their line manager. This provided an opportunity to address any issues and discuss any areas for improvement. In addition, senior staff carried out spot checks on the care staff to ensure they met people's needs and followed the care plans. The provider was planning to undertake annual appraisals for all staff by the end of the year. This indicated that people who used the service were being cared for by staff who were suitably supported.

The provider recognised the importance of food, nutrition and a healthy diet for people's wellbeing, and as an important aspect of their daily life. People's individual nutritional needs, likes and dislikes were assessed and recorded in their care plans. People were supported to shop for their food and cook in their flats if they wanted to. People had access to a restaurant at each of the extra care facilities which provided a range of meals and drinks throughout the day at a low cost. The cook was provided with details of people's individual dietary needs and was aware of people's nutritional needs. People's comments included, "It is very good food here", "The food is very nice and pretty good", "I can do my own food here. I do some cooking", "The food is good", "It is mostly basics but they do a vegetarian option and change the menu every three months" and "The barbecue on Sunday was brilliant." Relatives agreed and said, "Her appetite has improved so much" and "She enjoys her meals here especially the puddings."

We saw people enjoying lunch and were being appropriately supported in the restaurant of Cottesmore House and found the atmosphere to be happy and inclusive. However, we found that at Triscott House, none of the staff spoke with people apart from one kitchen staff who interacted with people and demonstrated their knowledge of them. None of the care staff engaged with people and did not seem to be supporting people to eat their meals where they needed individual support. We saw that two staff sat alone silently. One of them spent five minutes reading the newspaper. The radio was on throughout lunch, but when we started speaking with people, a member of staff turned the radio down without consulting people.

People told us the service was responsive to their health needs and a healthcare professional confirmed this. The care plans we looked at contained individual health action plans. They contained details about people's health needs and included information about their medical conditions, medicines, dietary requirements and general information. Records showed that advice from relevant professionals was recorded and actioned appropriately and regularly reviewed. For example, we saw guidelines in a person's care plan about how to deal with their medical condition and what action to take if they had concerns. Staff had received training in supporting people with a Percutaneous Endoscopic Gastrostomy (PEG) tube with their nutrition. This is a tube that is passed during a medical procedure into a person's stomach through the abdominal wall to provide a mean of feeding when oral intake is not possible or adequate. This showed that the service was supporting people with their health needs effectively.

People's care and support had been assessed before they started using the service. People who used the service had been referred by their local authority. The quality officer told us they assessed people once they had been referred before they moved into the service, to ensure the service could meet their needs. Assessments we viewed were comprehensive and we saw evidence that people had been involved in discussions about their care, support and any risks that were involved in managing/supporting their needs. People and relatives told us that they were consulted before they moved in and they had felt listened to. The healthcare professionals we spoke with said that the staff team provided a service which met people's individual needs and they had no concerns.

Requires Improvement

Is the service caring?

Our findings

Some people we spoke with were not complimentary about the care and support they received. We asked them if staff treated them with kindness and respected their human rights. Their comments included, "Lots of them just do their job, say goodbye and leave but the others are fantastic", "I'm not really sure about the carers. Some are alright I suppose", "The carers are very kind", "The carers are alright", "The weekday ones tend to be quite good but at weekends I think both the care and sometimes the cooking is poorer", "Some carers chat, some don't" and "The carers? Half of them just do the minimum, the other half are good, they do the little things that can make all the difference." Relatives commented, "Yes [family member] likes it here. He likes the carers and he enjoys the joking", "My [family member] has the best care here" and "The carers are so nice and you can see they care."

On the day of our inspection, we saw that some staff practices were not person-centred and did not always demonstrate a caring and respectful approach for people. For example, we noticed that staff provided functional and reactive support rather than anything proactive or individualised. Particularly at Triscott House, most of the staff sat quietly or whispered to each other, excluding people who used the service who were sitting in the same area. If a person requested support, they provided this with a lack of enthusiasm. On several occasions, at Triscott House, we walked around with a senior member of staff who told us they had noticed the fact that staff were sitting around not speaking with people. They also informed after the inspection, that they had addressed these issues.

We recommend that the provider seek relevant guidance with regards to improving person-centred care for people using the service.

Despite our observations, staff told us they respected people's dignity and privacy. One staff member stated, "We help people with washing, respecting their privacy like giving them the flannel and leaving them to wash privately."

People's cultural and spiritual needs were respected and they were supported to practice their religion if they wished. One person told us they attended church on Sundays and another was supported to attend Mosque on Fridays. Information about people's cultural background and religion was recorded in care plans. For example, one person's care plan stated, "I am a Christian and want to be treated with respect and kindness. [Staff] help me to observe Christian programmes on TV on Sundays."

The quality officer at Cottesmore House showed us a file entitled 'Nice things we do together'. This contained examples of when staff had recognised a particular need or a way to improve the quality of life of a particular person. For example, one person was anxious when their care worker was off duty, so the senior staff printed a picture of the person and the staff member together in the garden. This provided the person with comfort and reassurance. Staff identified that another person sometimes felt very low. By finding out what they liked doing, they were able to pair the person with another so they could read the bible and pray together. Staff reported that they noticed an improvement in the person's mood and wellbeing.

We saw a range of compliments received from people and relatives. Comments included, "Thank you for all the care and support you give to [Person]", "Thank you so much for all your help and support with [Person]", "Thank you so much for helping [Person] during the last two and a half years" and "I am very happy with [Senior staff] because [they] are nice and very good at their job."

Requires Improvement

Is the service responsive?

Our findings

The quality officer told us three people were receiving end of life care and were supported by the care workers, outreach workers and healthcare professionals. End of life care plans were in place for these people. However, we saw that none of the other support plans contained an end of life care plan. We discussed this with the quality improvement service manager who told us they would discuss this at the next quality meeting with a view of introducing this. They acknowledged that although it was a difficult subject to discuss with people, it was important for staff to know people's end of life wishes in order for these to be met when providing care at the end of their life.

As part of their care package, some people's care plans included information about their social and recreational needs and had plans about how these were to be met. The registered manager informed us that an activity programme was laid on for people who used the service. They told us that prior to rolling out the activity timetables, they met with people from both schemes and asked them what kind of activities they wanted and these were discussed and reviewed at the three-monthly Client Engagement Meetings at each scheme.

The provision of activities for people and the atmosphere between Cottesmore House and Triscott House were very different. At Triscott House, we saw an activity plan displayed and a list of events that were supposedly held every weekday afternoon. However, when we asked about the activities on the plan staff told us the activities do not always take place, which meant people's recreational needs were not being met as planned for them. Some people had outreach workers who took them out to undertake activities of their choice, such as going to a pub. One person told us, "Outreach people are very good and it is nice to get out." However, for people who were not receiving outreach support, there was very little stimulation and little opportunities to engage with the local community and to support people to continue to be a part of it. We discussed this with the management team who told us they would address this without delay.

We recommend that the provider review people's individual social and recreational needs in line with national guidance on this topic in relation to extra care settings

At Cottesmore House, we saw that staff encouraged and supported people to undertake activities of interest to them. People's comments about the activities included, "Fridays are good. It is music hour. That is good and my kind of music 99% of the time", "[Staff name] has happy hour on Fridays. That is fun", "The movies are boring" and "There have been a lot more activities here recently. When Carewatch took over, activities started." However, one person stated that "Weekends are really boring. Nothing happens here." The registered manager told us that they had recently held some weekend activities at both schemes, such as barbecues and royal garden parties.

There was a range of activities on offer to suit people's individual needs and which they could choose to attend. These included keep fit, music and drumming, bingo, movie afternoon, coffee morning, sing along, happy hour and arts and crafts. In addition, there were opportunities for people to be part of the local community through regular outings, including tea dances and pub lunches. People with a learning disability

were supported to meet other people and access the community as part of their care.

The care plans were developed from people's initial assessments and contained relevant information of the care needs of each person and how to meet these. People told us they were supported to remain as independent as possible and were consulted in all aspects of their care and support. Each person's care plan was based on their needs, abilities, likes, dislikes and preferences. We saw that all but one of the records we viewed were signed by people, which indicated that they had understood and agreed what had been recorded.

The service had a complaints procedure in place and this was available to staff and people who used the service. A record was kept of complaints received. Each record included the nature of the complaint, action taken and the outcome. Where complaints had been received, we saw that they had been investigated and the complainants responded to in accordance with the complaints procedure. For example, a person who used the service had made a complaint about staff. We saw that this had been dealt with appropriately and professionally. A review meeting had been undertaken and action had been taken to make the necessary improvements. This included allocating additional hours to the person's care package. We saw written feedback from the person saying, "I had several meetings with the office staff. We had some issues but it is all sorted now." People told us they were confident that if they had a concern, the staff and management would address it. Staff we spoke with confirmed they were aware of the complaints procedure and would be confident to make a complaint if they had to. One staff member said, "Such a massive difference now. If I want to talk about something, they listen. We work together."

Requires Improvement

Is the service well-led?

Our findings

The provider had put in place a number of audits to review the quality of the service provided to people. These included medicines audits, environmental checks and health and safety checks. The quality service improvement manager told us they also undertook a yearly audit of the whole service which lasted a week and included speaking with staff and people who used the service and checking records. However, these audits had not always been effective in monitoring and assessing the quality of services provided and in addressing any areas that needed to improve. This was because, although they had identified some of the issues we found during our inspection, they had not taken prompt action in relation to medicines, risk assessment and people not always receiving personalised care which reflected their needs.

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

The quality officer told us people were supported to feedback about the service through meetings and quality questionnaires. These questionnaires included questions relating to how they felt about the care and support they received and whether their needs were being met. It also included questions about the quality of the food, the environment and their social needs. People confirmed that they were invited to meetings. One person told us, "There is a residents' meeting every three or four months. Some things get done but not much" and another said, "I don't go to the residents' meetings. They are a waste of time, nothing gets done half the time." The registered manager explained that there were three monthly 'Carewatch surgeries' for people who used the service, as well as council led meetings to discuss housing related issues. They added, "The two are very different…. I cannot comment on whether concerns raised at the council led meetings are followed through or not."

Most people did not know who the registered manager was therefore they were unsure who was responsible for the running of the service. Their comments included, "Is it [Housing support staff]?", "I have no idea", "[Quality officer]. We see [them] as our manager", "Managers sit in the office and don't come out, except [Quality officer]", "No I certainly don't know the manager's name at all", "I haven't a clue who the manager is (We told the person the registered manager's name) I've never heard of [them]. We would like to see more of [them]", "No, I don't know the manager. We see [Quality officer] and [Senior staff]. We don't see the manager at all" and "[They] never come around to the flats to say hello or see us." A relative and a healthcare professional also confirmed they did not know who the registered manager was. We raised this with the head of extra care services, who told us they were surprised to hear this as the registered manager had ensured they attended meetings with people who used the service. They added, "I will speak to [Registered manager] and arrange some additional ways that [they] can make [themselves] known and available, I think it would be great practice to have a photo board up in each scheme showing who everyone is and their job titles and I will work with [Registered manager] on putting this in practice. "

Following our inspection, the registered manager told us they had sent a letter of introduction to every person using the service, and ensured they attended the Carewatch surgeries. They added that people were reminded to attend these events and were invited to make an appointment to meet with the registered

manager if they wished to. They also said that they had made a point of engaging with people during visits to each scheme, and had met with visiting healthcare professionals.

Staff were positive about their job. They told us they felt supported by the provider and were confident that they could raise concerns or queries at any time. Their comments included, "I really enjoy it. It's fabulous. I enjoy connecting with the residents. Management is pretty good. They have a lot to do and deal with. They take our concerns seriously, definitely" and "Yes, I feel listened to. We have had meetings and one-to-ones. The manager told us we can speak to her anytime. We have her number. We've had a few meetings. Communication is good."

Staff told us they had regular meetings. The items discussed included health and safety, training and issues concerning people who used the service. Meeting minutes were signed by staff indicating they had read and understood these. The quality officer and registered manager corresponded with staff regularly by email when a concern had been identified. For example, when staff were using their mobile phones whilst on duty. They also ensured they thanked staff and praised them for their hard work.

The registered manager kept abreast of developments in social care by attending the provider forums organised by the local authority. They also attended training and networking meetings which included lectures about different topics. They told us that all important information was cascaded to the staff team to ensure they were informed and they thrived to continue to improve their practices.

The service worked closely with healthcare and social care professionals who provided support, training and advice so staff could support people safely at the service. Records showed that professionals visited people at the home and had established good working relationships with staff.

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 provider did not ensure that care and treatment was always provided in a safe way for people using the service. Regulation 12 (2) (a) (b) (g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not ensure that systems and processes were established and operated effectively to assess, monitor and improve the quality of the service and to mitigate the risks relating to the health, safety and welfare of service users. Regulation 17(1), (2) (a) (b)