

London Borough of Redbridge

Fernways

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service

Fernways is registered to provide personal care and support to people living in specialist 'extra care' housing in London Borough of Redbridge. Not everyone who lived in the housing received personal care from the service. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service. People using the service lived in their own flats within a gated community where there were 52 properties. The service was providing personal care to 17 people at the time of the inspection.

People's experience of using this service and what we found

The provider had missed calls to people using the service, this related to staff absence and system failure. Medicines management required improvement; there were no protocols for medicines which were administered as and when required (often referred to as PRN medicines) and there were often gaps found in medicine administration records and no record of follow up with prescribing health professionals or GPs as to what to do if medicines were missed. Lessons were not always learned when things went wrong, incidents and accidents were not regularly discussed with staff.

Improvements were required in respect of governance systems at the service. We found a lack of systematic follow up or record of response to issues noted in staff communications. Similarly, records of communications with health professionals were not always recorded. There was no record of what occurred in staff handovers, and staff meetings did not contain rolling agenda items such as safeguarding or incidents and accidents.

We have made recommendation about recording people's end of life wishes.

There were systems in place to safeguard people from abuse. Risks to people were assessed and monitored. Infection prevention measures were in place.

Staff were supported through induction, training and supervision. The service worked alongside other agencies to provide effective care. People were supported with their health needs. People's needs were assessed so the service knew whether they could meet them or not. People were supported with their dietary needs. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People's equality and needs were recorded so staff could support people in culturally sensitive way. The service had received compliments about the care they provided. People and relatives were supported to express their views on the service. People were supported respectfully and their independence promoted. People received personalised care; their care needs were recorded in their care plans. People's communication needs were met. People were supported with activities. The provider was responsive to

complaints and concerns raised.

The provider had some quality assurance measures in place. While some aspects of their quality assurance systems did not work well, such as medicines audit follow up and incident and accident reporting, other aspects helped to improve the service, such as spot checks.

. People and relatives, we spoke with were generally positive about the service and staff working there. Staff knew their roles.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection

The previous rating for this service was good (published 08 December 2017).

Why we inspected

The inspection was prompted in part due to concerns received about people's care calls being missed. A decision was made for us to inspect and examine those risks.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement and recommendations

We have identified breaches in relation to safe care and treatment good governance at this inspection. We have also made a recommendation about recording people's end of life wishes.

Please see the action we have told the provider to take at the end of this report.

Follow up

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was effective.

Details are in our effective findings below.

Good ●

Is the service caring?

The service was caring.

Details are in our caring findings below.

Good ●

Is the service responsive?

The service was responsive.

Details are in our responsive findings below.

Good ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Fernways

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team

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.

Service and service type

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

Registered manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post. However, they had been absent from the service for longer than three months. The provider had made alternative arrangements to ensure the registered manager position was covered.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed the information we already held about this service. This included details of its registration, previous inspection reports and any notifications of significant incidents the provider had sent us. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke with one relative of someone who used the service about their experience of care. We spoke with 7 members of staff, including a manager, 1 administrator, 1 site warden and 4 care staff. We also spoke with a visiting health care professional.

We reviewed a range of records. This included 4 people's care plans and multiple medicines records. We looked at 6 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Following the inspection visit we spoke over the phone with 1 person who used the service and a further 7 relatives about their experience of care. We continued to seek clarification from the provider to validate evidence found. We looked at training data, information about activities and recruitment.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

- The provider had missed calls to people which meant people had not always received their care as planned. This inspection was brought forward due to concerns about missed calls. We found evidence of at least three missed calls concerning two people over the space of two days. We were concerned the provider would not have known the calls were missed as there was no system in place to ensure all calls were taking place.

Although we found no evidence that anyone had been harmed, systems in place to assess, monitor and improve the quality and safety of care were not effective. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We worked with the provider to understand how the calls had been missed and they subsequently adapted their call sheet monitoring to ensure there was a daily review of calls to people. We saw people had not been harmed as a result of the missed calls and had received subsequent calls either the same day or the following day. The calls had been missed as a result of unforeseen staff absence and were not a regular occurrence; The manager understood the benefit of a system change to ensure all calls were met.
- The concerns we had received were also related to a lack of permanent staff which had led to issues about staffing levels and missed calls. People and relatives we spoke with on inspection told us the provider had not missed any calls to their knowledge and they felt staffing levels were sufficient. However, staff told us, "[Staffing levels are] low. It can be hit and miss; we struggle at certain times. We have a few members off sick, we do our best to step in and cover [with] overtime."
- The manager for the service, who had only recently stepped up to cover long term registered manager absence, told us they had secured funding for permanent recruitment with the provider and were about to undertake a recruitment drive. They were also able to demonstrate long term agency staff arrangements which covered shortfalls in permanent staffing.
- Recruitment measures at the service were robust. Checks were completed on both permanent and agency staff before they started working to ensure they were competent and safe to work with vulnerable people. These included criminal records checks, employment history, employer references and proof of identification.

Using medicines safely

- Improvements to medicines management were required. We looked at four people's Medicine Administration Records (MAR) in their care plans, as well as numerous other MAR which had been audited. We noted there was information in people's care plans about their medicines; what should be administered

and when. We spoke with the manager about how care plans and or medicines related documentation could contain information about the risks associated with medicines, whether they have not been administered and or their side effects. The manager told us they would seek to make changes about this.

- There were no protocols in place for PRN medicines, which are medicines prescribed and taken as and when required such as pain relief medicines like paracetamol. We spoke with the manager about this, and they contacted prescribing medical staff so as to gain instructions and guidelines for staff as and when to administer and when to contact the prescribing health professional.
- We saw MAR audits were completed. Whilst these were of a good standard, they highlighted numerous gaps where people's medicines may not have been given. When this had occurred, there was no record of follow up with 111, GP or medical practitioner. The manager and administrator believed these gaps were due to carers failing to sign MARs though medicines had been administered.

Although we found no evidence that anyone had been harmed, the provider had not managed medicines in a safe and proper way. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We discussed our concerns with the manager and administrator, and they devised a means to ensure actions from audits were recorded and addressed. This resulted in changes made to their MAR audit form and individual call diary sheets so that actions relating to people's care needs could be identified and checked. The manager also told us they would request staff to sit their annual medicines competency assessments, given some of these were marginally overdue and as a result of the number of gaps in MAR discovered through audit.

Learning lessons when things go wrong

- It was not always clear if lessons were learned when things went wrong. It was not apparent whether Incidents and accidents were being discussed regularly as there was no record of handovers and incident and or accidents were not a recurring item on team meeting agendas. However, people and relatives felt the service worked well when incidents occurred. One relative said, "[Family member] has seizures and they [staff] are very fast to act. They call them an ambulance and always contact me when they have called an ambulance."
- The manager felt there were shortfalls with incidents and accidents being brought to their attention and had created an incident and accident spreadsheet so as to improve their capture of information and potential to learn lessons and improve care when things had gone wrong. They were also addressing this with staff as previous practice had been for staff to place incident records in care plans, where they may not have been addressed and acted upon by management in a timely fashion. The manager was only recently in post, and we could see they were seeking to implement changes to benefit the service.

Systems and processes to safeguard people from the risk of abuse

- There were systems in place to safeguard people from abuse. Staff told us, "Any forms of abuse or neglect, we would first inform our manager or the person on call and if it doesn't get resolved within that we take it further." The manager was able to show us staff had received safeguarding training and there was a safeguarding policy which staff had access to.
- Safeguarding concerns were raised with social workers and actions sought to mitigate potential abuse.

Assessing risk, safety monitoring and management

- Risks to people were recorded and reviewed regularly. Information was provided to staff to mitigate risks to people. Risks to people's health and wellbeing were assessed and recorded.
- We looked at four people's risk assessments and saw a variety of risks covered. Risk assessments

identified people's health conditions and social circumstances, the risks associated with them and what protection was in place to mitigate risk to them. For example, we saw risks noted for people around nutrition and hydration, mobility, mental health and infection prevention as well as other areas of their lives.

- Risk assessments provided information for staff to follow to mitigate risks. For example, risk assessments stated people's health conditions and what staff could do to keep people safe. There were instructions to contact the management, health professionals or emergency services if staff were concerned.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections. At the time of our inspection, some staff had recently contracted COVID-19. They were aware of this as they tested regularly and informed the provider. The provider had increased the testing regime of all staff as a result and tested people using the service who may have been affected. There had also been enhanced cleaning implemented to limit the risk of infection.
- We were assured that the provider was using PPE effectively and safely. There were ample supplies of PPE and staff had received training in PPE and infection control. The manager maintained an up-to-date folder with government guidance around COVID-19 and followed best practice in this regard.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. As this was an extra care service where people lived in their own flats, people had their own choices about their immediate environmental hygiene. However, the provider ensured communal areas, such as lifts, dining room and lounge area were cleaned regularly.
- We spoke with people and relatives who told us the service had been supportive when national lock down measures were in place. One relative told us, "Yes, they [staff] would take the [tablet device] and we would video call." Another relative said, "Their room and the whole place is spotless."

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Staff support: induction, training, skills and experience

- Staff were supported through induction, training and supervision. However, we noted there was no record of all agency staff having had an induction. We discussed this with the manager who stated agency staff did receive induction but admitted they had not been recording these. The manager promptly created an induction record for agency staff similar to permanent staff and also modified the existing template to demonstrate where new employees, permanent and agency, shadowed experienced staff.
- Staff received training to support them in their role. Most people and relatives felt there was no issue with staff knowledge and training, though one relative said "They have varying levels of expertise. They could do with a bit more training on Alzheimer's for one or two staff members." However, another said, "Yes, they are [suitably skilled and knowledgeable], they do a great job!"
- The manager maintained a matrix which showed most staff had completed all their training, though we saw some were due for refreshing. The manager was able to demonstrate they had identified this and sought to rectify it by speaking with all parties concerned to arrange training. We saw agency staff were offered the same training as permanent staff. Training topics included medicines administration, moving and handling and safeguarding. One staff member told us, "We've had specific training in the past. We can apply for it if anyone has autism, etc"
- Staff received supervision. There was a supervision planner to assist the manager, but the regularity of these had been hampered as the registered manager had been absent from the service. However, the covering manager had arranged supervision for all staff. Supervision notes we saw showed staff could discuss issues of concern and their own development.

Staff working with other agencies to provide consistent, effective, timely care;

- The service worked alongside other agencies to ensure people received consistent effective care. Whilst we flagged concern with some communication systems in place between management and staff, namely around incidents and lack of documented handover, we saw evidence of a variety of inter-working with other agencies and we spoke with one visiting professional whilst on inspection. They spoke positively about the service. They said, "They are lovely one to one, they are great. I've known them for years and I would recommend them."
- The service worked with and shared information with social workers, GPs, nurses and other health social professionals to provide effective care to people.

Supporting people to live healthier lives, access healthcare services and support

- People's health care needs were recorded in care plans and risk assessments. On occasion staff also

monitored people's health conditions to feedback to healthcare professionals. These included documenting nutrition and hydration. We also saw hospital passports in place to support people being admitted to hospital, providing information for hospital staff about how to support the person.

- The service supported people with their health care needs by referring to and maintaining communication with health care professionals. We met with one health care professional who told us staff at the service, "Let us know about the patients and for us to plan our visits - to review patients and for flu vaccination."
- We noted there was no specific systematic means of recording communication with health care professionals. We spoke with the manager about this and agreed it could be beneficial. They told us they would implement a system whereby records of communications of this kind would be recorded. Following the inspection, they provided us with information about how they would do this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were assessed before they began using the service. Assessments were completed by social workers who then referred people to the service. This was possible as the provider is a local authority. The manager would meet with colleagues who were registered managers of other services under the provider and they would discuss suitability of assessments and referrals and meet with people who were being referred to the service. Assessments were comprehensive and identified people's needs and choices, gathering information to ensure people's needs could be met by the service.
- Needs assessments, and their subsequent reviews, were the foundation of people's care plans and risk assessments. They recorded all important aspects of people's lives from their health conditions to their social situations. Assessments were in line with the law; identifying people's protected characteristics and ensuring their needs were met in a sensitive and culturally acceptable way.

Supporting people to eat and drink enough to maintain a balanced diet

- People were supported with their dietary needs. People's dietary needs were recorded in their care plan and they were supported to eat and drink where required. service was an extra care service and although people had their own kitchens within their flats, they also had the opportunity to purchase food from a communal kitchen onsite managed by the provider. We observed lunch in the dining area and saw staff working to ensure people's needs were met.
- Where people chose to use the communal dining area they were provided with a choice of food and their dietary information was shared appropriately so their dietary needs were met. If people had health conditions that affected their nutrition and hydration, such as diabetes, staff were aware as this information was available to them.

Ensuring consent to care and treatment in line with law and guidance

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 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.

- People were supported to make their own decisions and choices. People's decisions and choices were recorded by social workers who completed reviews of their care and these were then followed by the service. Where people could not make their own choices, the provider ensured meetings were held where

people's best interests were discussed, and people's wishes followed as much as practicable.

- People and relatives told us care was consented to and people were offered choices. One person told us, "I make my own decisions." A relative said, "I have power of attorney (legal status for decision making) but [person] is perfectly capable of asking for what he wants."

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection this key question was rated Good. The rating for this key question has remained Good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People's equality and diversity and their cultural needs were recorded initially at assessment and then repeated within care plans. People's faith, sexual and socialising preferences were all recorded.
- Staff received training in a number of topics related to how they work with and support people covering person centred care and equality and diversity.
- People and relatives told us people were treated well by staff. One relative told us, "I see [person], and they [staff] will bring them tea and make them feel comfortable." Another said, "[Family member] is always singing their praises they refer to her as mum or mama."
- The manager showed us numerous cards they received complimenting staff for the care provided. These highlighted how staff worked "hard" and had gone "the extra mile."

Supporting people to express their views and be involved in making decisions about their care

- People and relatives were able to express their views and be involved with decisions about people's care. People and relatives told us they believed people listened to them. One person said, "Yes [staff listen to me]."
- Care plans were signed to indicate people's involvement in care decisions. Relatives told us they were also involved in care planning. One relative told us, "I have her advanced care plan and I do all reviews."
- The manager's office was easily accessible to people and visitors and we observed people and relatives coming and going through out the inspection. This, along with regular spot checks and occasional surveys, provided opportunities for views on the service to be expressed.

Respecting and promoting people's privacy, dignity and independence

- People and relatives told us people's privacy and dignity were respected. One person said, "They are all friendly and respect my dignity." A staff member confirmed, "We maintain dignity and privacy. We do personal care in privacy and don't talk about people outside of work."
- People's confidential information was stored in locked cabinets and or on password protected computers.
- People's independence was promoted. Staff told us they promoted people's independence through encouragement and motivation. One staff member said, "We always get people to do as much as they can, encourage them where we can, to do things for themselves if they can"

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question Good. The rating for this key question has remained Good. This meant people's needs were met through good organisation and delivery.

End of life care and support

- Care plans did not always contain information about people's end of life wishes. We discussed with the manager that there should be a consistent opportunity for this to be explored with people.

We recommend the provider follow best practice with regards to working with people to address their wishes and preferences in relation to end of life.

- Staff received training and understood what good end of life care was. One staff member told us, "We have in the past [received end of life training] and it is also in the Care Certificate. To give them [people] good care, you have to keep them comfortable and keep them clean and respect their wishes."

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People received care that was personalised to them. People's care needs were recorded in their care plans, as well as their preferences and social circumstances. Social workers regularly reviewed people's needs, or as and when requested by service management, and this dictated how many hours of care were provided by staff at the service who sought to meet their needs.
- Care plans provided insight into people's lives and were accessible to staff, and also people and relatives, as they were kept in people's flats. This meant everyone who needed to, could see what support people required and what staff were expected to do.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The service recorded people's communication needs. One staff member said, "I think we know them [people] well. We know when something is wrong, we have a person in pain, and they cannot communicate this. We know this about them. They can't verbalise things. It's [communication needs] in their care plans." Care plans contained information about people's communication needs and preferences.
- One person had a communications passport to assist staff understand their communication needs. However, this was not in the person's care plan. The manager informed us this had been taken by hospital staff to support them after a recent admission of the person. Following the inspection, the manager arranged for a social worker review and communication passport replacement.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- This service was an extra care service which meant we would not always expect them to provide activities, though we would expect them to support people with this where possible. However, we saw evidence the provider offered bingo and keep fit in communal areas and arranged for a hairdresser to attend the service regularly.

Improving care quality in response to complaints or concerns

- People and relatives told us they felt they would be able to complain to the service if required. One relative said they would complain to, "The manager, never had cause to." The provider had a complaints policy and procedure which was available in people's care plans, which were kept in their flats.

- Complaints were recorded and responded to. Actions to improve care were recorded in the log and shared with others where appropriate.

- This inspection was completed in part due to concerns we had received. We saw how the provider sought to address these concerns when we shared them and were satisfied by their processes.

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- Whilst the provider had sought to ensure the service was always managed, we found concerns demonstrating it was not always well-led. The registered manager was unavailable for this inspection through long term absence from work. The provider had initially arranged cover by utilising registered managers from "sister" services also working within local extra care schemes run by the provider.
- The manager who supported the inspection, previously working in business administration at the service for the provider, had only recently been given their management role which enabled them to take responsibility of key requirements. We noted the manager had implemented a number of recent changes to improve systems at the service. However, at inspection we highlighted further areas which required improvement.
- There was no systematic means of picking up and following up on actions such as those recorded in the communication book. We saw entries such as "medicines refused" and concerns about people's health conditions and there was no way of verifying whether follow-up actions had been completed to ensure people were kept safe.
- Similarly, we noted there was no system for recording interactions with medical professionals other than if their instructions led to updates in care plans and or risk assessments. For example, we saw a medicine audit had picked up an anti-psychotic medicine had been discontinued for one person. The manager knew why this was, but there was no system in place to capture this and shared. We were concerned information could be lost in the event of staff absence or general emergency.
- There was no record of handover. This meant there was no way of knowing what exactly staff handed over from one shift to another and there was a risk that important information could be missed such as anything relating to people receiving their meals, not receiving personal care and or medicines not being administered. An example of this was evident in the concerns we received which led in part to our inspection.

The systems to assess, monitor and improve the quality of the service and to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users had not always been effective. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager implemented new systems and ways of working and was responsive to our feedback and

saw the inspection positively and as a means to highlight areas for improvement. They were keen to address shortfalls we highlighted as the inspection was ongoing. Following the inspection, they provided evidence of changes they were going to make to improve how the service worked.

- Staff meeting minutes showed meetings were taking place, though there were no regular rolling agenda items, such as discussing of incidents and accidents and or safeguarding concerns. The manager agreed regular agenda items would be beneficial for staff and stated they would make changes to their agenda.
- The provider had quality assurance measures in place. Regular spot checks observing staff undertaking their care duties were completed by the manager. Occasional surveys offered to people and relatives about the care provided.
- The provider recognised people had different cultural needs and sought to meet those needs where possible. This meant recognising and celebrating events from different faith calendars throughout the year and acknowledging different things were important to people from different backgrounds. As a local authority, the provider was able to draw on a variety of resources to meet people's needs in a person-centred way.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People and their relatives were positive about their engagement with the service. One relative said, "They have all been very friendly." Another relative said, "We can have face to face meetings to make changes and they always listen." People's equality characteristics were taken into account to ensure their engagement; the provider had arrangements in place to ensure people could engage in a variety of ways which suited them and their needs, in writing or verbally or through other people.
- Whilst people and relatives were positive, they were unclear who managed the service. We believe this related to the registered manager's absence. We were provided with four different names about who managed the service. Although this was the case, everyone felt confident their concerns would be dealt with appropriately if they raised them with the service.
- Staff had mixed views about whether they were listened to by the provider. One staff member said, "I don't know who to talk to at times." Whilst another said, "We need someone to listen and take things on board. It's difficult." Although staff told us this, they also went on to say, "[We have] team meetings, yes, about service users and yes we can affect change [to the care provided]." Meeting minutes we read covered COVID-19 and infection control, staffing and schedules and communications.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- When things went wrong the provider sought to address them. This inspection was brought about in part due to concerns we had received and we were able to see how the provider responded, from when we first shared the concerns with them and subsequently what they did.
- We were informed of apologies made to families, acting under duty of candour, and the provider being honest when something had gone wrong. Accidents, incidents and complaints were all recorded as well as any supporting actions completed by the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There were job descriptions for all staff roles. Staff told us they knew what they were supposed to do. The manager for the service knew their responsibilities, including to notify CQC as per regulatory requirements.

Working in partnership with others

- The service worked in partnership with other agencies to benefit people and their care. The service had numerous ties with GPs, district nurses, pharmacists and social workers. These relationships enhanced people receiving joined up care.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The registered person had not always ensured that service users were protected from the risks that can arise if medicines are not managed safely.</p> <p>Regulation 12 (1)</p>
Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The registered person did not always have effective systems to assess, monitor and improve the quality of the service and to assess, monitor and mitigate risks to service users</p> <p>Regulation 17 (1) (2) (a) (b)</p>