London Care Limited

London Care (Ensham House)

Inspection report

Franciscan Road
London
SW17 8HE

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07 February 2017

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

Summary of findings

Overall summary

This inspection took place on 6 and 7 February 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in. This was the first inspection of the service since it registered with the Care Quality Commission (CQC).

London Care (Ensham House) provides personal care and support to people living in an "extra care" housing scheme. This consists of 45 individual flats within a staffed building with some communal areas. At the time of our inspection there were 40 people using the service. A separate organisation managed the building. The flats comprised of a lounge/kitchen, bedroom and a bathroom and were individually furnished. There is a pleasant and secure garden with access from the ground floor. Each person was issued with a fob for access to the building.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People using the service were generally satisfied with the care they received, they told us they felt safe and that care workers respected their privacy and dignity. They said that care workers encouraged their independence and supported them to make choices.

The provider took steps to ensure people were fully involved and consented to the care and treatment they received. People were satisfied with the support they received with regards to their eating and drinking. They also said they had access to appropriate healthcare professionals if required.

We found that although risk assessments and care plans were in place, these were not always assessed and reviewed correctly. We found examples where risk assessments had not been completed correctly by staff and where care plans had not been updated following changes to people's support needs. We also found instances where care plans had not fully captured people's individual support needs.

Some aspects of medicines management were not safe. There were discrepancies in some of the medicines stock checks and where people's allergies were not made clear in medicines records.

Recruitment checks were robust which helped to ensure that people were supported by staff who were safe to work with them. However, we found there were not always enough staff on duty to support people using the service. There were instances where staffing levels were not at the level as stated by the provider. We also found that although staff received a thorough induction and ongoing training, they did not receive regular one to one supervision. We also received mixed feedback about the timeliness of the care workers and staff shortages from people using the service.

People told us they knew who to speak with if they were unhappy about any aspect of their care. We found that the provider did not always document their response to complaints and we found discrepancies in the paper and electronic recording of complaints.

Although thorough quality assurance checks, including audits and gathering feedback from people were in place, we found that the provider did not always act upon the feedback or the action points identified.

We found breaches of the regulations in relation to safe care, staffing, person centred care, complaints and good governance. You can see what action we have told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Aspects of the service were not safe.

Risks to people using the service were not appropriately assessed.

Although people were supported to take their medicines, the provider did not maintain adequate records.

There were not always enough staff on duty to support people.

Staff recruitment checks were thorough which helped to ensure that care workers were suitable to work with people using the service.

People told us they felt safe in the presence of care workers.

Is the service effective?

Requires Improvement

The service was not effective in all aspects.

Care workers did not receive regular supervision.

Staff training was thorough and refreshed annually.

People consented to their care and treatment and were able to exercise choice.

People were happy with the level of support they received in relation to their diet and access to healthcare provision.

Is the service caring?

Good

The service was caring.

People were happy with the caring attitude of care workers.

People said they were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not responsive.

Care plan reviews were not always effective in identifying people's support needs or any changes to their support needs.

The provider did not always document complaints received and action taken in response to complaints received was not always clear.

Is the service well-led?

Requires Improvement

The service was not well-led in all aspects.

Quality assurance checks were not effective in picking up concerns.

Feedback from people was generally positive about the service and how it was managed.

London Care (Ensham 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 checked 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 6 and 7 February 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in.

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.

Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service. We also discussed the service with the contracts monitoring team at the local authority.

During the inspection, we spoke with 10 people using the service, two relatives and nine staff members including the regional director, the area manager, the registered manager, the scheme manager and care workers. We also spoke briefly with a visiting GP and pharmacist. We looked at eight care records, six staff records, training records, complaints records and audits related to the management of the service.

Requires Improvement

Is the service safe?

Our findings

We found that risks were not identified correctly in all cases, and were therefore not adequately mitigated against to protect people from avoidable harm. People were at risk of not having their needs met as care plan documentation was not always appropriately completed or up to date and did not always accurately reflect peoples changing needs.

Care records included environmental, falls and mobility, nutrition, skin care and skin integrity assessments. There were also external risk assessments in place such as Occupational Therapy (OT) moving and handling risk assessments and therapy advice transfers from the community team. Each of the care plans contained some risk management assessments, however we found that these were not always being completed correctly.

A falls prevention risk assessment for a person identified at high risk of falls was last completed in June 2015. Since that time, this person had suffered a number of falls and the risk assessment had not been updated. One person who had a seizure in November 2016 did not have their care plan or their risk assessment updated to reflect this or demonstrate how staff could support this person in a safe manner.

A Waterlow score (or Waterlow scale) gives an estimated risk for the development of a pressure sore in a given person. We saw that the provider was not always using this tool correctly. One Waterlow pressure score completed in February 2016 was not scored correctly. The provider had failed to consider the person's age when calculating the risk. We reviewed another Waterlow for a second person, which again was not scored correctly.

The mobilising risk assessment score was rated by severity and likelihood. The score for one person was incorrect as the likelihood and severity of the risk had not been totalled correctly. In a second example, instead of giving a score as per the guidance, the staff member had just populated whether they were at high, low or medium risk. The general mobility for one person was incorrectly scored as medium but it should have been high, their movement in bed was incorrectly scored as low but was actually a medium risk. This showed that staff did not have clear and consistent information about people's healthcare needs and associated risks to their safety and wellbeing.

Some aspects of medicines management were not safe. The care plan for one person stated that their morning call was supposed to take place between 10:00 and 10:30. Their notes stated, 'care worker to give my lansoprazole as I have to have it on an empty stomach.' However, on the day of the inspection this person was given their medicines after they had their breakfast. The care worker attended to this person at 11:00.

This person was taking pain relief such as co-dydramol and paracetamol as needed, however administration of these medicines was not always recorded on their medicines administration record (MAR) chart. We counted the tablets that were present and we found a discrepancy of 6 between what we counted and the last count that was carried out by the provider.

The nutrition and skin care assessment for one person said the person was allergic to oranges (no citrus juices), this was not mentioned in the person's MAR chart.

The above identified issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback from people about whether they felt there were enough staff on duty. Whilst some people thought there were enough staff on duty, others did not think so. They said, "When I use my chord, they come quite quickly", "When I call for help, they do come quickly, even at night", "I don't get out very often because they need to be with me and there aren't enough staff", "I think there is a shortage of staff", "I feel there is a shortage of staff because they come and do what they need to and then go", "There are shortages of staff, especially at weekends", "When I call in my room, it can take up to ten minutes to get a response" and "Having a spare staff member would help to take up the waiting times."

One relative that we spoke with on the day of the inspection told us they were still waiting for a care worker to attend the morning call. They said they ended up making the breakfast for their family member themselves.

Staff, including the scheme manager also commented that sometimes they felt staffing levels were a concern and they did not always have the required numbers of staff on duty. The scheme manager told us, "On weekends, we often have difficulties. If the care workers give us enough notice, we try and find another care worker", "There are times when I have had to come in because we are desperate" and "We allocate according to eight care workers as the ninth sometimes doesn't turn up." Comments from staff included, "If care workers do not turn up, the team leaders have to do the caring", "It's really hectic in the morning. I do feel rushed", "If we get an extra floater for the morning and afternoon, that would help" and "Sometimes the time allocated is not enough."

The registered manager told us that normal staff levels were nine care workers between 07:00 and 14:30, eight care workers between 14:30 and 22:00 and two waking care workers at night. However, we saw on occasion that staffing levels had not been at this level in the weeks leading up to the inspection which could potentially have impacted on the care provided. We looked at the staff rotas from 02/01/2017 up to the week of the inspection with the scheme manager. In that period, there were at least seven occasions where the staffing levels had fallen below the expected level as stated by the scheme manager.

We reviewed some quality assurance records and saw comments from people in reference to staff shortages, people had highlighted issues related to having regular care workers and timeliness of care workers. Some of the complaints that we looked at were also in relation to these issues. In the tenants team meeting held in October 2016, people had raised concerns around the continuity of care and not knowing which care workers would be attending.

In a service quality survey that was carried out in May 2016, where 12 surveys were returned, 55% of the respondents felt that too many different care workers visited them and 91% said they were not told which care workers would be visiting them.

The above identified issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service said they felt the service was a safe place to be and they felt safe with staff. Comments included, "There is no agro with any of the staff", "Yes, I feel safe here", "The staff are nice and I

do feel safe with them", "I'm fine (safety) here and I'm very happy" and "I'm very safe in their hands." People were given information about protecting themselves and others in a service user guide that they were issued with when they first came to live at the service.

Care workers were familiar with safeguarding procedures, how to identify potential signs of abuse and who to contact if they had concerns about a person's welfare or safety. Training records showed that care workers had received training in this area which included working through scenarios that they may have to respond to.

Staff recruitment was managed centrally through a HR department. Staff files contained evidence of application form, eligibility to work in the UK, literacy and numeracy assessments, interview, a reference verification form and the signed contract. The reporting system was able to pull out reports in relation to staff. We checked this system which showed that there all staff employed had Disclosure and Barring Service (DBS) checks in place. The DBS provides information on people's background, including convictions, in order to help providers make safer recruitment decisions.

People told us they were generally satisfied with the support they received with their medicines. Comments included, "The GP issues prescriptions and the pharmacy makes up packs for me and delivers them", "I get my medication automatically every five weeks", "Someone collects my medication", "They supervise me taking my tablets twice a day", "I take my own medication and I do so in front of them (staff)" and "My medication is supervised by staff."

The provider used a medicines risk assessment to record people's consent in relation to the level of support they required with medicines. This was based on four levels of risk. Level 1 meant the person had capacity and was able to self-administer their medicines, level 2 was for people with capacity but needed physical assistance such as opening medicines containers, level 3 were those people who did not have capacity and had their medicines administered and level 4 was specialised medicines administration. The scheme manager said, "10 people self-medicate, we deliver the medicines to them but don't complete the MAR charts."

Requires Improvement

Is the service effective?

Our findings

Although training was delivered and refreshed annually and on site supervision took place regularly, we found that office based supervision was not carried out as regularly as stated in the provider's policy. The managing staff policy and procedure said "All employees will have an office based supervision session with their line manager at least every three months. On site supervision at least once every six months. Each employee will receive an appraisal at least annually". Office based supervisions were an opportunity for staff to discuss employment related issues, service related issues, health and safety, health issues and administration.

One care worker who had started working for the service in February 2016 had only one recorded office based supervision in September 2016. A second care worker who had started work in June 2015 had two recorded office based supervision sessions in March 2016 and June 2016. A third care worker who started work in March 2015 had only one recorded office based supervision in June 2016. One care worker one who had started in March 2015 had no office based supervision sessions recorded. Therefore, we could not be assured that staff were receiving the support required to enable them to meet people's needs effectively.

The above identified issues are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

Care workers told us they were happy with the level of training they received. Comments included, "The training is thorough", "The training is good, it's refreshed regularly" and "The OT comes in and tells us how to use the equipment."

Induction was a five day programme, built around a service user called 'Cathy', and at least two days shadowing. 17 different areas were covered, which included introduction to caring; assisting and moving, diabetes awareness, person centred outcome focussed care, dementia, first aid, safeguarding, food safety, nutrition and hydration, privacy, dignity, independence and choice. Each area included a workbook and assessment which care workers completed and were tested on.

After completing their induction, care workers completed observational shadowing training and competency assessment based around person centred care, safeguarding, communication, health and safety, safeguarding, moving and handling, personal care, continence, infection control, medicines and nutrition. This was where a team leader observed them carrying out their roles practically in a 'live' environment.

All care workers refreshed their training annually through the completion of two workbooks, the first was 'care and welfare' which included medicines, safeguarding, a Mental Capacity Act scenario, safeguarding scenario, dementia and first aid. The second workbook was called 'safe working' which included health and safety, fire, food safety, infection control, assisting and moving. Staff files contained evidence of training that care workers had completed.

Team leaders also carried out on site spot checks and competency assessments at regular intervals looking at basic compliance, general practice and mental capacity, care and support tasks, health and safety, medicines management, specialist tasks, recording and safeguarding. The provider also had specific themed supervisions if gaps in care worker's understanding or poor practice had been identified. Themed supervisions were available for medicine, safeguarding, mental capacity, nutrition and hydration, skin integrity and record keeping. A team leader told us, "We do observations during spot checks, how they communicate, engage and how they prepare food" and "The spot checks are seeing them doing it practically. I observe the medicines, ask them questions."

People using the service told us that their healthcare needs were managed well. They said, "They (staff) would call my GP if I needed", "If I need the doctor, I book it with the office", "I arrange a visit from my own doctor" and "The district nurses come in to do the daily dressing."

The registered manager told us they had recently contracted a GP to come to the service on a weekly basis. Staff contacted the surgery on a Friday with details of people to be seen on the Monday. The scheme manager told us, "We've got a really good relationship with the pharmacist and the GP. If I'm in doubt, I can always call them."

Input from healthcare professionals such as speech and language therapist feeding recommendations were included in care plans. We spoke with a visiting GP and pharmacist on the day of the inspection who did not raise any concerns with us.

People using the service prepared food independently or received support from care workers and had their meals prepared and provided for them in their own apartments. We were not able to observe people being supported with their meals as the people ate their meals in their own flats. They said, "They cook my meals for me, they are kept in my fridge", "My [family member] prepares meals for me in advance and puts them into the freezer. The staff then prepare my meals daily", "If you want them to cook for you, they will", "They take a list and shop for you", "My food is prepared and I get it when I want", "I do my own shopping and they do my readymade meals in the microwave", "They do my meals for me" and "I make a shopping list and give it to them weekly."

There was a large dining area on the ground floor which was open to people and their relatives to meet up. On Fridays, fish and chips were ordered in and people ate together. There was a large well equipped kitchen area for people, relatives and staff to use.

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.

Care workers had received training in the MCA and were aware of the importance of asking for people's consent before supporting them with personal care. They said, "You have to support them individually, if someone does not feel like being supported, you cannot force them", "I always ask them before helping them" and "Mental capacity is about helping those people that cannot make decisions for themselves."

People were consulted about and consented to their stay in the service. People using the service, their family and their social worker were fully involved in the decision to live in their flats. The registered manager

told us, "We expect people to answer some of the questions on the initial assessment themselves."

Care records included details about how people gave their consent, and people using the service and their family members (where appropriate) were involved in planning their care. People had signed their service user agreements indicating their consent. People told us their care plans were reviewed and staff came round to go over their care plans to ensure that they understood them and agreed to the content.

Good

Is the service caring?

Our findings

People using the service were happy with the care and support they received from staff. Most said the personal care was good and the care workers were kind, caring, helpful and respectful.

Comments included, "They (staff) are nice girls", "Some staff are kind", "One particular staff member is very helpful", "Mostly the staff are charming", "The staff are all nice and honest", "The staff are friendly and I'm quite friendly with some of them", "The staff are very nice and kind. We have a laugh and a joke", "I have absolutely no problem with the staff" and "I do feel well looked after."

People appeared well dressed and groomed. One person told us, "I have my hair cut downstairs." They told us that care workers respected their privacy and dignity. One person said, "They do respect my wish to shower myself." Another said, "They respect my privacy and also give me space". People lived in their own flats and their personal care was carried out in the privacy of their own flats. Care workers were aware of the importance of respecting people's privacy and dignity when supporting them with personal care.

We also observed some interaction between care workers and people using the service and this was seen to be kind in nature. Care workers were observed to be patient with people when dealing with them. They addressed them according to their preferred names. A care worker told us, "When we are attending to a resident and get a call from another one, we try to let them know that we will be there in a while after finishing with the other resident." The communal areas were calm during the day and there was a friendly atmosphere.

People said that staff encouraged them to be independent but if they needed help with anything were always willing to help. They said, "To get around, I have an electric scooter in a shed downstairs", "I like to be a bit independent", "Staff do respect my wish to be independent", "They help me wash and dress", "They help me in the morning with a shower and breakfast", "Sometimes they help with my laundry in my bedroom", "I try to be independent but can leave things to be done by the carers when they attend", "I do my own cleaning and cooking", "The carers do my washing every morning" and "They do the shopping as well for me when they can." A relative told us, "[My family member] is independent with [their] personal care but needs help with meals. They usually get ready meals."

Family contact was encouraged and people said they could have visitors at any time. They said, "My family can come and go", "I can have visitors at any reasonable time and I can let my visitors in" and "Visitors can pop in anytime to see me" and "The best thing is I have my own space and my visitors can visit easily." Rooms were available for relatives to stay in, if they wished. One relative told us they found this a nice feature of the service. This meant they could spend some quality time with their family member.

In a service quality survey that was carried out in May 2016, people using the service fed back that staff treated them with courtesy and respect, were caring and upheld their dignity.

Requires Improvement

Is the service responsive?

Our findings

We saw some examples where people's care plans had not captured all the relevant information or had not been reviewed after certain incidents. One person had suffered a seizure in November 2016 but their risk assessment and care plan had not been updated after this incident. Their last care plan review was carried out in April 2016. One person had left the service on a number of occasions and there were concerns about their safety, however there was no reference to these incidents in their care plan reviews.

We also saw a record from a healthcare professional indicating a person had diabetes, however this was not referenced in the person's care plans.

We could therefore not be assured that care planning was effective in capturing people's individual support needs and how these should be met.

The above identified issues are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

We found that on some occasions, people had not received a response to their complaint within the timescales as stated in the providers' policy and some complaint investigation reports had not been completed. One relative said, "I had an acknowledgement but no formal response to date." We saw a complaint had been received in January 2017 and an acknowledgement had been sent but the deadline for responding had passed. We asked the registered manager and the scheme manager for the outcome of this and were told there had been a delay as some of the records they needed to see had been archived.

We found that although complaints were recorded, there was a discrepancy between those that were recorded in the paper records and on the provider's own reporting system called the Branch Reporting System (BRS). Some complaints were recorded on paper but not BRS. For example, in one complaint from November 2016, there was nothing recorded in the complaint investigation record. The scheme manager said this had been completed but the records had not been uploaded onto the BRS system.

We also saw incomplete records on BRS. There were complaints on BRS going back to October 2015 that were still open on the BRS system, it was therefore difficult to see if they had been resolved to the satisfaction of the complainant, although the registered manager told us they were.

In an audit that had been carried out in August 2016, one area of improvement that had been identified was that BRS had responses to complaints that remained outstanding.

The above identified issues are a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

People using the service told us they had made complaints before and knew who to contact when doing so. Comments included, "I have complained about being short staffed", "I've never complained, but would to

the manager" and "I have complained about the toilet seat in my flat being loose and they fixed it." The complaints procedure was included in the service user guide that was issued to each person using the service.
We spoke with the registered manager about the process of referrals. All of the people using the service had been referred by the Local Authority. There was a link care co-ordinator from the Local Authority in place who sent though nominees. These were reviewed by the scheme manager to assess their suitability for a placement within the service. People using the service, their family and their social worker were invited in to go through their requirements. The provider carried out its own assessment during which their support plan was agreed. People were given the opportunity to see their flat and make an informed decision about wanting to live there.

The registered manager told us that care and support plans were reviewed initially at six weeks and thereafter yearly unless people's needs changed. The registered manager told us, "We keep a copy of care plans in people's rooms and one in the office" and "The care plans are reviewed yearly, unless needs change."

There was a section entitled 'my care and support plan'. Outcomes for people were recorded here and included areas such as support with personal care and hygiene, support to take medicines, support to prepare meals and maintaining a clean living environment. Care records contained a section called personal information and one called 'me and my life' in which person centred information was captured.

Each person had a booklet that was kept in their flat and completed by care workers during every visit. These were completed monthly and audited at the end. They covered the following areas, diary log records, medicines records, financial records, skin care and meals records. We sat in on a staff handover which took place at every shift. Care workers discussed GP visits and any other relevant information regarding people using the service, including any changes or support needs.

The service was a supported living scheme therefore people were independent and whilst some said they arranged activities between themselves, others preferred their independence, so choice was exercised. Comments included, "I don't take part in any activities", "I have choice and I choose to stay in my room", "I go to the coffee morning sometimes", "I go downstairs to the entertainment, if I fancy it", "We arrange entertainment sometimes", "I don't take part in any of the entertainment" and "There are monthly residents' meetings."

No formal activities took place at the service, however the provider did organise coffee mornings twice a week, a movie night and a weekly fish and chip supper. There was a communal lounge on the ground floor and a hair salon which had recently opened. A hairdresser attended based on bookings made. A librarian visited every three weeks so people could borrow books to read.

Requires Improvement

Is the service well-led?

Our findings

Most people and the relatives we spoke with were complimentary about the manager and the management of the Home. However, we found that some areas of the service were not well managed.

Some care workers raised concerns about general morale within the staff team, these were related mainly to their rates of pay and pressure they felt under with respect to staff shortages. They told us, "Staff are concerned about wages", "We need to have a volume of care workers that are regular. We have a low rate of pay so end up being the last resort", "The main issue we have is getting the right and enough care workers on the weekends. We can be short staffed" and "The wages are not great."

The provider did not always accurately record incidents that occurred. The provider used an online system called the Branch Reporting System (BRS) to collate information related to a number of areas from incidents, complaints and staff records. The information that was uploaded to the system was overseen by the registered manager and the provider's quality team. The registered manager told us that care workers reported any incidents in the communication book and the senior team would complete an investigation report and would also record these on BRS. We looked at the incidents that had been logged on the BRS.

We saw one incident when a person had a fall and an ambulance was called but the incident report was not fully completed and was also not included in the BRS. There was another incident of challenging behaviour that was only recorded on paper and not on the BRS. We also noted that some of the incidents that were logged on paper were not fully completed. There was a section entitled corrective and preventative action and follow up and resolution which were not completed.

Some of the complaints that we saw were in relation to an incident that took place. Notifications had been submitted to us but these had not been documented on the provider's incident log, one where a person had a seizure in November 2016 and where a person using the service had left the service and there were concerns about their safety. Therefore we could not be assured that these incidents were appropriately managed and responded to.

We also found that although there were frequent quality assurance visits completed by team leaders and regular residents meetings, feedback and action that had been identified from these was not always followed up.

A quality assurance visit in October 2016 for a person had documented that they were dissatisfied however this was not fully explored by the staff member and the record stated that no changes were required.

In three separate quality assurance visits for another person that took place in September, October and November 2016, the person said they wanted regular carers, had trouble telling care workers what to do each time, and also that care workers came at different times. These comments although documented, where not responded to or explored further.

Tenants meetings were held every three months, issues discussed included activities, bills, safety and defects. In the meetings that had been held in March and October 2016, concerns were raised around the continuity of care and people said they did not know which care workers would be attending to support them. The action from the October 2016 meeting was the provider would send a rota to people letting them know who would be attending, however this had not been actioned at the time of our inspection.
There were a number of quality assurance checks in place. An internal quality team carried out inspections every three months based on specific areas. The quality team and regional manager completed a branch visit record on a monthly basis. Some of these were general and others based around specific areas such as medicines. There were some issues around medicines identified in these visits which were assigned to branch managers and care workers but we could not see any evidence where these issues were discussed in group supervisions or team meetings.

A medicines audit completed in March 2016 had scored the provider 47% and in September 2016 64.6%, which indicated that an improvement had been made in this area. This audit had identified that those completing MAR charts should attend the medication officer lead training for team leaders, however we found that not all had done this.

An internal audit completed in May 2016 looked at nine areas that included safety and security, service management and comments and complaints. The outcome was that the service was rated as high risk with a compliance rate of 65.3. In the audit completed in September 2016 the provider had scored 65.1, still a high risk.

The above identified issues are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

People were generally positive about the care they received, telling us, "Nice manager and it seems to be well run", "The service here is good, not excellent", "Security and warmth is the best thing here", "Overall, I'd rate this service as good", "The best thing is there is someone to hand to call if needed", "The best thing is being able to get the care when I need it", "The flat is the best thing here and the carers are very good", "The best thing here is [my family member] can be attended to when she needs it" and "Overall, the service is alright."

There was an open door policy, the manager's office was on the ground floor and people using the service came to the office throughout the inspection. People were comfortable approaching staff in the office.

There was a registered manager at the service, however there was a scheme manager who managed the service on a day to day basis. There were two team leaders at the service, and a vacancy for a third and a weekend team leader. The primary roles of the team leaders were to manage the care workers and carry out audits and spot checks, although they did care work if required.

Care workers we spoke with told us they felt supported by the scheme manager who was approachable and helpful. They said, "The scheme manager is supportive." I feel supported by the scheme manager", "[The scheme manager] is approachable. She understands and gives us flexibility."

Branch manager meetings were held every three months and information from these was cascaded to the staff team within the service. The most recent branch managers meeting was held in December 2016. Care workers meetings were held every three months, we saw records of these from February 2017, October 2016 and June 2016.

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 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users did not meet their needs and reflect their preferences. This was because the registered person did not design care and treatment in such a way as to achieve service users' preference and ensure their needs were met. Regulation 9 (1) (b) (c) (3) (b)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not assess the risks to the health and safety of service users of receiving the care or treatment and did not do all that was practicable to mitigate against identified risks. Regulation 12 (1) (2) (a) (b) The provider did not carry out proper and safe management of medicines. Regulation 12 (1) (2) (g)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints An accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity was not established and operate effectively. Regulation 16 (2)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were not operated effectively to ensure compliance with the requirements in this Part. Regulation 17 (1)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not deploy sufficient numbers of staff to meet the requirements of these regulations. Regulation 18 (1) Persons employed by the service provider in the provision of a regulated activity did not receive appropriate supervision as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a)