Hill Homes Care Limited

Trees

Inspection report

2-4 Broadlands Road
Highgate
London
N6 4AN

Date of inspection visit:
18 March 2016

Date of publication:
27 April 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 18 March 2016 and was announced. We told the provider 48 hours before our visit that we would be coming. We gave the provider notice of our inspection as we needed to make sure that the registered manager or another appropriate member of staff would be available in order for us to carry out the inspection.

This inspection was the first inspection of this service since it was registered with the CQC in March 2015.

The service provides personal care for people living in an extra care scheme. Extra care schemes are places which enable people to live independently but can access tailor made and flexible care support when required. At the time of the inspection, Trees, was providing care to 25 people. The service provides personal care, escort and support services to older people some of whom are living with dementia or have physical disabilities.

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

On the day of the inspection we visited the extra care scheme, which included the service's main office. On entering the scheme we found that the environment was welcoming and clean and when walking around the scheme we observed there to be a calm and relaxed atmosphere.

People who used the service felt safe and secure with the staff that supported them with their care needs. The provider had taken steps and arrangements were in place to help ensure people were protected from abuse.

The provider had recruitment and selection procedures in place to ensure that the staff employed by the service were safe to work with people. However, the service did not always verify references to ensure that references received were by the person completing the request.

Staff that we spoke with demonstrated that they had the knowledge and skills they needed to perform their roles. People that we spoke with confirmed this. However, training records that we looked at and the service's training matrix highlighted that some staff had not received training especially in mandatory subjects such as Mental Capacity Act 2005 (MCA) and medicine administration.

The registered manager explained that staffing levels were determined based on the number of shifts that needed covering and people's level of need. However, some staff that we spoke with told us that they felt that there was not enough staff allocated per shift to meet the need of all the people they provide care to.

People received personalised care that was responsive to their needs. Care plans were person centred, detailed and specific to each person and their needs. Risks associated to people's needs and requirements were assessed and were personal to the person receiving care. People had seen their own care plan and were consulted on a regular basis to review and record their care preferences. Care plans were signed by people or their relatives receiving care.

People were able to make their own choices and decisions. The registered manager and care co-ordinators were aware of the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). When speaking with the registered manager we identified that some people living at the scheme may be subject to a DoLS authorisation as they lacked capacity and were unable to leave the building of their own free will. The registered manager told us that she will speak to the local authority DoLS team to gain further advice in this area. Staff we spoke with had a basic understanding of the MCA but had not received any formal training in this area.

During the inspection we observed positive caring relationships had been developed between people who used the service and staff and people were treated with kindness and compassion. People were treated with respect and dignity. Staff not only provided prompt assistance but also encouraged and promoted people to build and retain their independent living skills.

There was a clear management structure in place starting from the chief executive through to the registered manager, care co-ordinators and the care staff team. The service had systems in place to monitor the quality of service provision. However, they were yet to implement annual quality assurance questionnaires for people, relatives and stakeholders to complete, in order to receive their feedback and to learn and improve service provision.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff were aware of the different types of abuse and what actions to take to protect people. The service assessed risks associated with people's individual care needs.

Staffing levels were determined by the number of calls that required covering and people's level of needs. Rota's that we looked at showed that a minimum of four staff members were always on duty, however, people and staff told us that they felt there could be more staff available.

We saw that appropriate arrangements were in place in relation to the recording and administration of medicines.

Is the service effective?

Requires Improvement

The service was not always effective. The service did not ensure that all staff received regular training particularly in mandatory subjects.

People were able to make their own choices and decisions. The registered manager was aware of the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff had a basic understanding of the MCA but had not received any training in this area.

Staff received regular supervision meetings in line with the provider's policy.

People had access to health and social care professionals so as to receive appropriate care and treatment.

Is the service caring?

Good

The service was caring. We saw that people were treated with kindness and compassion and interactions between people and staff was personal and person centred.

People were involved in making decisions about their care and staff took note and acted upon people's individual needs and preferences.

People's care plans were person centred and detailed and included people's preferences, likes and dislikes. People's independence was promoted.

Is the service responsive?

Good

The service was responsive. The service had a complaints policy in place and there were procedures for receiving, handling and responding to complaints.

The service employed a staff member that was responsible for supporting people with their well-being and organising and delivering and activity programme responsive to people's needs and requirements.

People were consulted regularly about their care and support needs. People knew who their key worker was and monthly key worker meetings were held to review their care and support.

Is the service well-led?

Good

The service was well-led. We saw that the registered manager had systems in place to monitor and audit systems in order to improve the quality of care provision.

The service was yet to implement quality assurance questionnaires for people who use the service, their relatives and other stakeholders.

Staff told us that they felt well supported by the registered manager and could approach them or any other member of the management team if they had any issues or concerns.

The home had a clear management structure in place starting from the chief executive and registered manager through to the care co-ordinators and care staff team.

Trees

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 18 March 2016 and was unannounced. The provider was given 48 hours' notice because the location provides a domiciliary care service within an extra care scheme and we needed to be sure that the registered manager or another appropriate person would be available to help us with the process.

The inspection was carried out by two inspectors. One inspector visited the service and the other inspector made phone calls to relatives of people who used the service and staff members to obtain their feedback about the service.

Before we visited the service we checked the information that we held about the service and the provider including notifications and safeguarding concerns affecting the safety and well-being of people. We also contacted the local commissioning team in order to obtain their feedback about the service and the provider.

During this inspection we observed how the staff interacted with and supported people who used the service. We spoke with four people who used the service, four relatives, the chief executive, registered manager, two care co-ordinators and six care staff.

We also looked at six care plans, four staff recruitment files, training records and records relating to the management of the service such as policies and procedures, audits, medicine records and risk assessments.

Good

Is the service safe?

Our findings

People that we spoke with told us that they felt safe and were happy with the care that they received. On person told us, "Oh Yes, I feel safe" and another person told us, "I feel safe. It makes a difference to know there is someone to support you." One relative that we spoke with told us, "They know how to care for my mum. She is safe with them." Another relative told us, "They do their jobs well. It's a safe service."

Safeguarding policies and procedures were in place to help protect people and minimise the risks of abuse to people. The policy was detailed and described the different types of abuse, how to identify actual or possible abuse and what steps to take when abuse has alleged to have occurred. Care staff that we spoke with were able to identify the different types of abuse and knew that any concerns should be reported to the registered manager. Two staff members that we spoke with told us, "If we saw or heard that someone is being abused we would check and report. We believe what our tenants say and we are very protective of them" and one of the staff members also told us, "If I know someone is unhappy, I am uncomfortable and I won't go home until I have checked them."

Most care staff had received training in how to safeguard adults. However, from the training matrix that was provided, we saw that some staff members had not received training in safeguarding. We highlighted this to the registered manager who told us that they would ensure, where gaps had been identified, that these staff would receive this training.

Staff we spoke with were aware of whistleblowing and were confident about raising concerns about any poor practises witnessed. Staff knew that they could report their concerns to the local authority and the CQC.

Risk assessments had been completed for people who used the service and were individualised based on people's personal, behavioural and specific medical needs and requirements. Risk assessments detailed the area and identified hazard, known triggers, likelihood of occurring, who might be harmed, existing control measures and any further actions. Risk assessments were in place for various areas such as fluid retention, sight deterioration, poor hearing, catheter care, weight loss and pressure sores. The provider had recently introduced a system whereby all staff were required to read care plans and risk assessments for people that they supported and then sign to confirm that this had taken place. Staff we spoke with confirmed this and were familiar with the risks associated with people's support and knew what steps needed to be taken to manage the identified risk.

The provider had appropriate systems and processes in place to ensure safe recruitment of staff. We looked at recruitment records for four care staff and found enhanced criminal record checks had been undertaken prior to a staff member commencing work, two written references had been obtained and proof of identity and the right to work in the United Kingdom had also been obtained. However, we did see that some recruitment files were not complete in relation to lack of application forms and interview notes. We highlighted this to the registered manager who told us that this was due to staff transferring from another agency under the Transfer of Undertakings (Protection of Employment) regulations (TUPE) process where

full documentation was not handed over to the provider as part of that process.

We also noted that as part of a local authority audit which took place in November 2015, the provider was advised that on receipt of references, they carried out verification of the reference by calling the referee to confirm that they were the person completing the reference. The registered manager advised that since this audit they have not recruited any new staff member but will begin to implement this process as soon as someone new is recruited.

The registered manager told us that they occasionally use agency staff from an external source. The service had a folder which included agency staff profiles and also included a completed induction checklist which the provider undertook with the agency staff member and copies of some of their training certificates.

We looked at the staff duty rotas for the last four weeks. The registered manager explained how staff were allocated on each shift. Staffing levels were determined based on the number of staff required as per the total of shifts that required cover. Staffing levels were also determined based on people's level of needs. An example was given where one person required a higher level of support and therefore extra care support in terms of staffing numbers was provided.

However, some people that we spoke with felt that staffing levels was an issue especially when regular staff were granted annual leave. One person told us, "Due to annual leave they have had to employ agency staff." Care staff that we spoke with also felt that there wasn't enough staff. One staff member told us, "We run short of staff on occasions because of annual leave and sickness. We are in the process of recruiting." We highlighted people's concerns to the registered manager who confirmed that they were in the process of recruiting more staff.

The provider had policies and procedures in place for the safe management and administration of medicines. Policies and procedures available provided guidance to staff on providing support with medicines, assistance with administration, disposal of unwanted medicines, non-compliance with medicines and training in medicine administration. We looked at a sample of Medicine Administration Records (MAR) and found that there were no unexplained gaps. People's medicines were kept within their own flats. The registered manager completed weekly and monthly medicine audits which looked at stock levels and gaps on the MAR sheet where staff had not signed to confirm that the medicine had been administered. The registered manager told us that gaps on MAR sheets was an on-going issue but had improved over the last few weeks. The provider has had to implement additional systems to monitor this and as a result the chief executive had been meeting with individual staff members to discuss this issue as part of their personal development.

Staff records that we looked at confirmed that most staff had received training in medicine administration but, again, there were gaps in the training where some staff had not received any training. This was highlighted to the registered manager who confirmed that they would look into this and arrange training as soon as possible.

The service maintained an on-call system whereby an allocated senior carer or care co-ordinator would be responsible for the mobile phone so that when someone rang their emergency call bell the allocated staff member would be alerted and would call the person immediately to confirm whether the person was okay and what support or assistance they required. People we spoke with told us that staff were quick in responding to the call bell.

The service maintained weekly and monthly fire safety checks. The service had a 'stay put' policy in place

which directed people to stay in their own flats until someone came to assist them in the event of a fire or any other emergency. This was due to the fire safety design of the building which allowed for people to remain in their own flats for a length of time without being placed at risk of the fire spreading. Each person had a profile sheet which outlined how the person was to be supported in the event of an emergency. Emergency procedures were clear and staff knew what to do in the event of an emergency. Evacuation plans were displayed in the service accommodation.

The service held an accident and incident folder. Details of incidents or accidents that had occurred had been recorded which included the time of the incident and what action was taken. The service was also pro-active in reporting incidents and accidents where appropriate to the local authority.

All care staff had full access to personal protective equipment (PPE) at any time when required. We observed that care staff were able to come to the office and collect whatever supplies that they required.

Requires Improvement

Is the service effective?

Our findings

People that we spoke with told us that they felt staff had the knowledge and skills to perform their job. One person told us, "They do a lot of training here" and another person told us, "I think they are fairly good, I have no complaints." One relative we spoke with told us, "Most of them know what they are doing. Sometimes the new ones could do with a longer induction."

Staff were positive about the training they received. One staff member told us, "There seems to be no end to the training as we can ask if we need any" and another staff member told us, "We have lots of training, we cover medicine, dementia, manual handling, Parkinson's disease and safeguarding."
Training records showed that care staff had completed training in areas that helped them when supporting people. This included topics such as moving and handling, medicine administration, safeguarding, first aid, fire safety, dementia, human rights and food hygiene. We looked at the training records of four people and the training matrix which covered all staff members and the training they had received. Records confirmed that some staff had received training in the above areas however, the service was not consistent and did not review training records to ensure that all staff members received training in all areas including medicine administration, safeguarding, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

This was a breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that all staff received an induction. The induction took place over two weeks and covered topics such as personal safety, introduction to support and risk management plans, health and safety and an introduction to the tenants. A checklist was completed and signed at the end of the induction. Staff that we spoke confirmed that they had received an induction prior to commencing work. One staff member told us, "I shadowed more experienced staff before I was able to work alone."

We spoke with staff and looked at staff files to assess how staff were supported to fulfil their roles and responsibilities. Staff told us that they received regular supervisions and confirmed that these sessions gave them the opportunity to raise any queries and concerns. One staff member told us, "We have regular supervision. I am supported. I feel listened to. I'm happy." Another staff member told us, "I meet the manager for supervision every 1 to 2 months." We looked at the supervision records for four staff members, which confirmed that discussions at supervision covered topics such as evaluation of previous supervision targets, key worker issues, care support plan reviews and general work performance. We saw evidence that some staff had received an annual appraisal but not all staff had as most people had not completed a year of employment with the provider. The registered manager, however, did have systems in place which highlighted when staff members were due for their appraisal.

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. When speaking with the registered manager we identified that some people living at the scheme may be subject to a DoLS authorisation as they lacked capacity and were unable to leave the building of their own free will. The registered manager told us that she will speak to the local authority DoLS team to gain further advice in this area.

The registered manager and the care co-ordinators had a clear understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). A MCA policy was available. Care staff demonstrated a basic understanding of the MCA. One staff member told us, "If we noticed any change with a person and their capacity we can report it to the manager." They were also aware of the importance of ensuring people were involved in decision making and where people were unable to make decisions, the importance of involving their families. Care plans also contained information about people's mental health.

However, when we looked at the training records for staff we noted that none of them had received any training in MCA and DoLS. The registered manager also confirmed that this was an area of training that needed to be delivered. We highlighted this as a concern to the registered manager and the day after the inspection we received confirmation that training had been booked for the end of March 2016.

People told us that staff always sought prior consent before carrying out any tasks. Care plans evidenced that consent to care was obtained and where possible care plans were signed either by people themselves or, where they were unable to sign, a relative had signed on their behalf. People we spoke with told us, "I am always given a choice and they do ask me what I want." A relative told us, "My relative can say what they want and they ask. I'm still involved in the care." During the inspection we observed care staff obtaining consent in areas such as entering the person's flat or what they would like to eat or drink.

The service provides care services within an extra care scheme. The service was not involved in menu planning for people as many of them either prepared their own meals or were able to make choices and order ready-made meals which were delivered to their flat. Care staff would then assist people to prepare some elements of the meal or support with heating up pre-ordered meals. For one person the service had employed an Asian care worker who supported the person to prepare culturally specific meals according to what the person liked. The service also supported some people with going shopping in order for them to buy day to day items of their choice. The provider also organised for meals to be cooked by care staff on Wednesdays and Sundays, where people could come together in the communal lounge and dining area and enjoy their meal together. One person told us, "Carers make a Sunday lunch and we can go and have a good chat. They also make meals from different nationalities."

Care staff were not always able to monitor peoples' food and fluid intake as they were only available at the person's home for a limited period of time and in some instances only once during the day. However, if staff did have any concerns about a person's poor food and fluid intake, these were noted in the daily record notes and highlighted to the registered manager and/or family members.

People were supported to maintain good health and had access to healthcare services and received ongoing healthcare support. Care plans detailed people's health and medical needs. Most people were able to contact the GP or nurses themselves when they required support. We saw records of referrals to health services where people needed support with pressure area care or needed to see the dentist or chiropodist. One person told us, "They make an appointment for me when I need to." Another person told us, "I just phone down to the office and they request a GP for me." However, one relative did comment that they would like the service to be a bit more proactive with recognising when their relative needed to see the doctor.

Good

Is the service caring?

Our findings

People that we spoke with told us that staff were caring. One person told us, "They are very nice carers, very respectful." Another person told us, "They are a friendly lot, I feel a part of the family." Relatives that we spoke with also told us, "The staff are good, really kind" and "They are very caring. They take their time with my relative."

We observed interaction between staff and people who used the service during our visit and saw that people were relaxed with staff and were confident to approach them. Staff interacted positively with people, showing them kindness and respect. There was a relaxed atmosphere and staff we spoke with told us they enjoyed supporting people living within the extra care scheme. People had free movement around the communal areas and could choose where to sit and spend their recreational time. During the inspection we observed care staff visiting all the people living at the scheme and included especially those who received care from the provider and those who did not regularly leave their flat. This was to ensure that people were okay and to check if there was anything they required.

Staff were knowledgeable about people's likes and dislikes. Care plans were person centred and contained detailed information about the person, their preferences and wishes on how they wanted to be supported by care staff. Care plans that we looked at also included minutes of monthly key worker meetings that were held with the person and their allocated key worker. These meetings gave people the opportunity to talk about their support needs as per their care plan and as a result the care plan would be updated by the key worker. People that we spoke with knew who their key workers were and also confirmed that these key worker meetings took place. One person told us, "I review my care plan every month with my key worker. I chat with my key worker and then sign the care plan. I feel involved in my care."

People and their relatives told us that they felt involved in the care planning process and the reviewing of their care plan as and when necessary. One person told us, "My key worker is [staff name]. The manager also comes up to see me and review my care needs." Relatives told us, "They are nice carers, they ask my relative what they want and make regular checks on my relative." Staff also understood the need for people to be involved in the planning of their own support needs. One staff member that we spoke with told us, "I think the family is involved in care plan reviews. We follow these and these tell us what people like and dislike."

Staff were aware of the importance of treating people with respect and dignity. Staff understood what privacy and dignity meant in relation to supporting people with personal care. Staff told us, "I close the door when doing personal care" and "I'd never fully undress someone when doing personal care." People told us that staff always maintained their privacy and dignity when supporting them with personal care. One person told us, "they always knock on my door before entering and ask my permission" and one relative told us, "They do respect privacy, they knock before entering."

In addition to this, people told us that they were supported by all staff to maintain their own independence as much as they could. One person told us, "I am very much aware of what I can and can't do. The staff always support me and they don't let me put myself at risk." Another person told us, "This is a place that

helps you to be independent."

We spoke to the registered manager and two care staff members about supporting people who were lesbian, gay, bi-sexual or transgender (LGBT). The registered manager told us that LGBT people used the service. Although they did not receive care from the service, staff were aware of their needs and requirements. The two staff members that we spoke with told us, "The couple are not treated any differently in comparison to anyone else living at the scheme. No one bats an eyelid." The registered manager also told us that they had scheduled LGBT and equality and diversity training for all staff members in April 2016.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs and requirements. Care plans that we looked at contained detailed information about the person's likes and dislikes, medical history and care support needs. This included a plan outlining the support the person needed with various aspects of their daily life such as managing continence, personal care, meals and nutrition and mental health. There was evidence that people were involved in completing their care and support plans and we saw that care plans had been signed by people themselves to show that they had agreed to the care they received. One person, whose signature was not eligible, was still encouraged to sign their own documentation and a note was made next to their signature identifying that this was the person's own unique signature.
However, in some cases, key information that was held on the person's main care plan had not been transferred over to the care plan that was held in people's flats. For example, where someone had a catheter in situ, this information had not been transferred on to the care plan held at the person's own home. Direction on when the catheter had to be changed was also not noted. Therefore, care staff would only be knowledgeable about this if they read the main care plan. We highlighted this to the registered manager who agreed and confirmed that this information would be reviewed and the care plan would be updated where required.

The service completed a pre-assessment of needs prior to providing care. Information collated as part of this assessment included personal information, communication, making decisions, health needs, emotional and mental well-being, mobility and accessing the community.

Care staff that we spoke with had a good understanding of what person centred care was and how they delivered this through the support they provided to people. One staff member said, "Caring is also about their well-being and their mental health. I treat people like I would treat my own." One person living at the scheme required culturally specific meals and needed a care support worker to assist in preparing these meals. The service recruited a care staff who could meet the specific dietary needs of this person.

The provider employed a staff member whose role was to support and maintain the well-being of people living at the extra scheme. This person had only been in post over the last six months but people that we spoke with were very complimentary of the work that they were doing. One person told us, "(The staff member) has done a lot. Very recommendable. They have introduced different exercises and have got people from outside to deliver talks and information sessions."

The well-being co-ordinator was responsible for organising a variety of activities for everyone living at the scheme. A weekly newsletter was produced which gave information about the forthcoming activities for the week and other information which would be of direct interest to people living at the scheme. Activities organised included poetry and story-telling session, art class, quizzes, Indian head massage, yoga and exercise classes. One person told us, "They organise very nice classes, poetry and story-telling and a lovely art class." Relatives told us, "The number of activities on offer now is really good. They have poetry and all sorts, I commend them for that." Another relative said, "They have lots of things going on and take my relative for a walk on nice days."

The service had a complaints folder in place which contained their complaints policy and a record of all the complaints that they have received. There was a log of complaints which contained information about the complaint, what action was taken to resolve the complaint and the response the service provided to the person who made the complaint. Complaint records that we looked at had been promptly responded to. People and relatives that we spoke with confirmed that they were able to approach the manager if they had any concerns. One person said, "I know who to complain to" and another person said, "I don't have any complaints." Relatives told us, "I'd speak to the manager if I wasn't happy" and another relative said, "If I wasn't happy I'd contact the manager for help. She is very helpful and always resolves things quickly."

The service also maintained a record of all compliments that were received. These included comments from visiting professionals, relatives and people who used the service.

Good

Is the service well-led?

Our findings

People and their relatives were positive about the management and were happy with the service that they received. People told us they knew who the manager and felt comfortable in approaching them with any issues or concerns they had. One person told us, "I feel quite comfortable going to the manager."

Staff that we spoke with were generally positive about working at the service and the support that they received from the registered manager. Staff told us that morale within the organisation was good and that staff worked well with one another. One staff member told us, "I love it here, this is my second home, we get really good support here. All our staff are approachable and that's what makes us good." Another staff member told us, "The manager is approachable and helpful. Any queries you can go to her. She doesn't stay in the office, she helps out."

Staff told us that they attended monthly staff meetings which covered topics such as medicines, values, CQC and training. We saw minutes of these meetings. One staff member told us, "We are actively encouraged to share our own ideas."

Some staff that worked in the service had sensory impairments. They told us that they were well supported in relation to their disability and were supported to carry out their roles. They told us, "My colleague wants to work nights and we have told the manager about this and they are going to look at ways to do it despite our disability" and "I couldn't ask for a better workplace, we are not excluded just because of our disability." However, one staff member whom we spoke with did not feel supported especially in relation to their health needs.

During the inspection we met with the chief executive of the provider. The chief executives role was to oversee the entire management of the service as well as the overall scheme. The chief executive told us that they met on a weekly basis with the registered manager and was available on call at any time for guidance and support especially in case of an emergency. The registered manager also confirmed this.

The service had regular tenant's meetings so that people were able to discuss issues regarding the management of the service with staff and management. Topics discussed included fire safety, care and support, health and well-being, housing and building maintenance. People we spoke with confirmed that these meetings did take place and we saw minutes of the meetings which confirmed this. Minutes were sent round to all the tenants after the meeting had taken place. One person told us, "We have regular meetings but I feel that the carers don't receive feedback from these meetings." Another person told us, "I have attended the tenants meetings which are once every month." Relatives we spoke to told us, "I think they could do with more formal meetings with relatives. I speak to the manager and the carers all the time but it's informal. I'd like them to be more formal and for them to make suggestions about the care."

The registered manager had a number of quality assurance systems in place to monitor and improve the quality of the service. Documents that we saw assured us that the registered manager had good management oversight of the service. Weekly and monthly medicine audits were completed as well as care

plan and risk assessment audits. One care plan that we looked at did not have any risk assessments on file as this person was relatively new to the service and immediately on arriving at the service had been admitted to hospital. On discharge the service had not finalised the person's risk assessments. When we highlighted this to the registered manager they showed us care plan audits which they had completed which had picked up that the risk assessments had not been completed. The audit also recorded the action that had been taken to ensure these risk assessments were put in place. This included a supervision session with the key worker to discuss the issue and actions to be taken.

The registered manager told us that they have not carried out any annual satisfaction surveys since they began providing a service. The provider is planning to introduce questionnaires which will be distributed to people who use the service and their relatives from April 2016. A draft questionnaire was sent to the CQC after the inspection with confirmation that these would be completed during the month of April 2016. Although, since the well-being co-ordinator had been recruited, they had introduced well-being feedback forms which people were asked to complete after a well-being session had taken place. These forms also asked people for their comments and suggestions for future events.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always receive regular and role specific training as is necessary to enable them to carry out the duties they are employed to perform, Regulation 18 (1)(2)(a)