City of Bradford Metropolitan District Council

Wagtail Close

Inspection report

23 Wagtail, 15-21 Wagtail Close
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Our inspection of Wagtail Close took place between 22 February 2018 and 2 March 2018 and was unannounced. At our last inspection in December 2016, we found breaches of legal requirements relating to safe medicines management and good governance. At this inspection we found improvements had been made to medicines management and the service was no longer in breach of this Regulation. However, we found insufficient improvements had been made in relation to good governance and the service remains in breach of this Regulation.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of safe management of medicines and good governance to at least good. We found medicines administration sheet (MARs) were well completed and people were receiving the correct medicines. However, robust quality systems should have identified and actioned some of the concerns we found at inspection such as accuracy of care records, financial management of some people's monies, listening to people's views about the running of the service, taking actions as a result to improve the service.

This service provides a domiciliary care agency and a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The domiciliary care agency provides personal care to people living in their own houses and flats in the community, some of which are based in 'extra care' facilities. It provides a service to older adults and younger disabled adults. Wagtail Close provides a respite care unit and accommodates three people in one adapted building. The domiciliary care service was providing personal care for 122 people at the time of our inspection;some people receiving personal care from the domiciliary care live in the extra care services of Dove Court, Mary Seacole Court and Eden Gardens. Some people receive night care support but this is provided currently by another agency.

A registered manager was 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. The registered manager was supported by locality managers based at each of the 'extra care' facilities.

Most people or their relatives told us they felt safe with the service provided. We saw staff had been trained to recognise signs of abuse and appropriate referrals had been made to the local authority. However, we found more robust systems were required to protect people from the risk of financial abuse. Following our inspection the registered manager put extra safeguarding measures in place to mitigate this risk. However, this should have been identified and actioned prior to our inspection.

Medicines were mostly managed safely and the service was no longer in breach of Regulations regarding the

safe management of medicines.

Accidents and incidents were recorded and the registered manager was taking steps to ensure outcomes of these were fully documented, including lessons learned. Risks to people's safety were assessed and care plans put in place to mitigate these risks.

Sufficient staff were deployed to keep people safe. Some concerns were expressed by staff cover during night time and agency staff, with concerns raised about some staff not being fully aware of people's care and support needs. The registered manager was aware of this and told us this was being reviewed. Staff were recruited safely and were subject to annual appraisal and regular supervision. We saw the separate areas of the service had their own training matrixes and most staff training was up to date or booked. We have made a recommendation about the service maintaining accurate and clear systems to ensure staff training is kept up to date.

Most people and/or relatives told us the service met their health care needs and took action if they were concerned about people's health. Our review of people's care records confirmed this.

The service was meeting the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberties Safeguards. We saw evidence of consent being sought during our inspection although more evidence of people's consent to care and support needed to be present in care records.
People were satisfied with the food on offer at Wagtail Court and said a good selection of meals were available to choose from. People who received support with their meals within the domiciliary care service told us they were satisfied with the food prepared by staff.

People and their relatives told us some staff were caring and treated them with compassion and kindness whereas they felt other staff had a less compassionate and caring approach. Staff respected people's privacy and dignity.

Although people had individualised care records in place, these did not always reflect up to date and accurate information. For example, clearer and more accurate guidance was required for staff who supported people with their nutritional intake. Care records needed to show more evidence of people being involved in the planning and review of their care and support. This lack of evidence reflected what some people and/or their relatives told us about not having taken part in care planning or reviews.

Although there had been no formal complaints we saw a complaints policy was in place and displayed at Wagtail Close. People told us they knew how to make a complaint if necessary.

Activities were offered at Wagtail Close according to people's preferences and they were made welcome at social events at the provider's extra care service next door.

People and staff spoke positively about the management team and said they could approach them with any concerns. We found the registered manager open and keen to make improvements within the service.

Some people and/or their relatives told us their views about the service quality had not been sought and some people told us they did not feel listened to. Some people told us when their views had been sought they had not been told of any actions taken as a result.

Although a system of audit and quality assurance was in place, this had failed to recognise some of the concerns we found at inspection. This meant the provider was not meeting the requirements of the law and

was in breach of Regulations.

You can see what action we told the provider to take at the back of the full version of the 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

The service was not always safe.

Improvements were required to the recording of people's finances to ensure people were not at risk of financial abuse. Although actions were taken following our inspection we were concerned audits in place had not highlighted these concerns and actions taken sooner.

Sufficient staff were deployed and plans were in place to address concerns raised about staff cover at night time. Staff were recruited safely.

Medicines were mostly safely managed.

Is the service effective?

Requires Improvement

The service was not always effective.

Most people and/or relatives told us the service met their health care needs and took actions if they were concerned about people's health.

People told us permanent staff knew their care and support needs but expressed concerns about the skills of agency and non-permanent staff.

Staff and people told us consent was sought during care and support. However, further evidence of consent needed to be present in people's care records.

The service was compliant with the legal requirements of the Mental Capacity Act (2005).

Is the service caring?

Requires Improvement

The service was not consistently caring.

People and their relatives had mixed views about the care and support received. People told us staff respected their privacy and dignity.

Staff we spoke with knew people's care and support needs as well as their likes and dislikes.

People were not always involved in planning and reviewing their care and support needs.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records did not always accurately reflect people's current needs or offer detailed guidance on how to offer people care and support. Care reviews needed more evidence to reflect people's involvement in the process.

People were supported with activities according to their personal preferences.

A system was in place for recording and responding to complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality assurance systems had failed to identify and act upon concerns we found at inspection.

People did not always feel their views about the quality of the service were sought or actions taken as a result of their views.

Staff praised the management team and told us they were supportive and approachable. The registered manager was open to looking at positive improvements for the service.

Wagtail Close

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.

Our inspection of Wagtail Close took place between 22 February 2018 and 2 March 2018. The inspection was announced. We gave the service 48 hours' notice of the inspection visit because it is a domiciliary care service and a respite unit and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

Our inspection site visit activity started on 22 February 2018 and ended on 2 March 2018. It included speaking on the telephone with people who used the service and relatives on 22 and 23 February 2018 and interviewing staff members on the telephone on 28 February 2018 and 2 March 2018. We visited the office location on 26 February 2018 to see the registered manager and office staff; and to review care records and policies and procedures.

The membership of the inspection team consisted of two adult social care inspectors and four experts-by-experience who completed telephone calls to people who used the service and/or their relatives. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The experts-by-experience on this occasion had experience of caring for older people and people living with a learning disability.

Prior to the inspection we gathered and reviewed information about the service from a number of sources. This included notifications received from the provider and contacting the local authority safeguarding and commissioning teams. As part of the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This had been returned in a timely manner and we took the information within the PIR into account when making our judgements.

During our inspection we used a number of different methods to understand the experiences of people who used the service. We spoke with nine people who used the service, 21 relatives and 9 care staff on the telephone and spoke with the registered manager, a staff member, the chef and three unit managers at the service. We looked at elements of 10 people's care records, some in detail and others to check for specific information, medication records and other records which related to the management of the service such as training records and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

Safeguarding policies and procedures were in place to keep people safe. Staff had received safeguarding training and were able to give us examples of different types of abuse and how they would report these. We saw appropriate safeguarding referrals had been made to the local authority and the Care Quality Commission.

Most people told us they felt safe at the service with comments such as, "I feel very safe with them and with living here", "I feel safe living here; nobody can get in without a fob", "I've no concerns at all about [person's] safety", "[Person] is safe there; I go once a month" and, "Without a doubt, [person's] safe at Woodside Court (extra care service where people receive personal care from the service). It's very hard to get in and out and to be honest they all look out for each other and the carers are great with [person]. [Person] loves living there and it's lovely and clean." However, some people and/or relatives expressed concerns about security of some of the units, with one person saying, "There's no security here, they don't lock the door during the day and anybody off the street can walk in. They don't lock the door until six o'clock." We asked the registered manager and the unit manager about this. They told us that people were able to lock their own front doors but the nature of that particular accommodation meant the front door was not locked during the day time but they would review the security in light of the comments received. Another person's relative commented, "[Relative] has vascular dementia and Alzheimer's and I don't think [person] would know how to call for help in an emergency. It's my only concern but they're so busy it's sometimes 11:00am when they come and I worry that [person] could be on the floor and no one is there early."

The service held small amounts of personal money for people who used the service. People's money was kept securely in the office safe and the unit manager kept a record of all transactions. Staff also had their own system and were logging money on a separate sheet and keeping receipts in people's care records. We found three months of receipts in one person's care records. This highlighted that the locality manager was not completing detailed audits of people's finances; the receipts had not been logged back in with the change, the records were confusing and this had not been highlighted at audit. We saw one person's care records detailed they had previously been financially abused. The service managed this person's money. However, there was no finance risk assessment or support plan to guide staff how to do this safely.

We spoke with the registered manager about our concerns. They told us they did not complete overarching monthly audits on people's finances currently to make sure people's money was being managed properly. This meant people were at from the risk of financial abuse. Following our discussion with the registered manager, they met with the locality manager of the service to discuss our findings. New procedures were immediately put in place, a financial risk assessment was completed and the registered manager confirmed they would now be completing monthly audits to mitigate the risk of financial abuse. We saw evidence this had been put in place following our inspection. However, we were concerned these areas of concerns had not been identified and addressed prior to our inspection.

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

At the last inspection in December 2016 we found the service was in breach of Regulations regarding safe management of medicines. At this inspection we found improvements had been made and the service was no longer in breach of Regulations.

The service had a medicines policy in place which referenced current legislation and guidance. Staff had received training in medicines administration and received regular observation. We saw people's medicines were kept in locked cabinets in their apartments. Medicines administration records (MARs) were in place and completed correctly. This gave us assurances that people were receiving medicines correctly. People's relatives told us, "They both get their medication on time. Everything is logged down", "[Person] always gets [person's] medication when [person] should," and, "They always give [person's] medication in a morning, it's all written in the book." Some people's relatives raised concerns about previous medicines errors and we saw these had been reported, investigated and actions taken to prevent the error happening again.

Protocols were in place that clearly described when medicines prescribed for use 'as required' should be administered although for some people these required more detail. For example, we saw full medication profiles were not present in some people's care records informing staff what medication the person had been prescribed, including possible side effects for staff to be aware of, why the medicines were being taken and any contraindications.

Medicines were audited weekly and monthly and we saw where these had highlighted concerns with actions taken as a result. We completed a random check of boxed medicines at Wagtail Close and found amounts tallied with the amounts documented. Systems were in place for ordering and disposing of medicines safely.

We saw there was a recruitment and selection policy in place which showed all candidates were required to complete an application form and attend a formal interview as part of the recruitment process. The registered manager told us during recruitment they obtained two references and carried out Disclosure and Barring Service (DBS) checks for all staff before they commenced work. These checks identified whether staff had any convictions or cautions which may have prevented them from working in the caring profession. We looked at six staff employment files and found in most, appropriate checks had been made prior to employment to ensure staff were suitable to work with vulnerable people. However, we saw two staff files where the person's employment history was missing. The registered manager investigated and sent us evidence following our inspection which confirmed the information was present on-line, or had been discussed at interview.

Staff we spoke with told us sufficient staff were deployed to keep people safe and they had enough time in to each call to complete required care and support. We looked at the staff rotas which confirmed this. We looked at some people's call visit records and saw staff mainly stayed for the allocated length of time in each call although times were not always recorded in people's daily records. People we spoke with told us staff usually stayed for the correct amount of time although some commented about staff arriving late if there had been an emergency elsewhere. The registered manager told us they were changing the system for night cover since they were aware this had been a source of concern for some people. This was confirmed by some people who told us they were not happy with the staff cover at night time, which was provided by a separate agency.

Accidents and incidents were recorded in detail and accurately. Records showed the registered manager completed thorough investigations and analysis into incidents and accidents. However, information relating to the outcome was not always recorded and there was no evidence of lessons learned as a result. The registered manager told us they would implement this straightaway. From their response we had confidence this would take place.

Care records demonstrated risks to people's health and safety were assessed and plans of care put in place for staff to follow. This included risks associated with equipment such as bed rails and hoists. However, more detailed information was required in some assessments about how to complete the activity safely.

We saw moving and handling techniques documented in one person's care records that were not standard practice. There was no information present to say when this had been agreed or who had assessed it as being safe. We spoke with the registered manager who investigated and confirmed this had been agreed and documented by a senior occupational therapist a few years prior who had since left the service. They forwarded details of the information and confirmed they had organised for the provider's moving and handling assessor to reassess and they had confirmed the practice was still appropriate for the person's needs.

We looked around Wagtail Close and saw the premises was clean and well maintained, with an improvement plan in place to redecorate and refurbish some areas. We saw people were encouraged to bring some personal possessions such as photographs to personalise their apartments, although the service was a short stay respite unit. One person told us, "Always clean and nice in the communal areas with no bad smells," and another commented, "It's a lovely place. It's clean, looks nice and doesn't smell." We saw personal protective equipment (PPE) such as gloves and aprons were stored in people's flats for staff to use when providing personal care and support.

We saw records indicating fire alarms and evacuation procedures were tested regularly. People had personal emergency evacuation plans (PEEPS) in their care records and/or behind the front door of their property. Appropriate safety checks were in place and updated to ensure the safety of Wagtail Close, such as gas, electric and water checks. Equipment such as hoists, bathing aids and lifts were serviced and maintained safely.

Requires Improvement

Is the service effective?

Our findings

People's care needs were assessed and appropriate plans of care put in place. The service worked with a range of health professionals to develop care plans. Care records showed people had access to a range of health and social care professionals such as GP's, district nurses, dieticians, opticians and dentists. Where required, we saw appropriate equipment such as hoists and bed rails was in use. We saw people had been assessed for equipment appropriately.

Where staff were concerned about people's health or had noted a change we saw they had made referrals to health professionals. Most people and their relatives told us staff supported them well with their healthcare needs. We saw one relative had sent a written compliment to Wagtail Court about staff responsiveness which stated, 'Keen observations of staff...managed to get [person] the immediate care and treatment [person] needed by getting an ambulance and getting [person] into hospital.' This demonstrated how staff had worked with healthcare professionals to deliver effective care, support and treatment. One person told us, "If I've got an upset tummy or something, they'll put an extra check call in, and keep an eye on me." A relative said, "They seem to be able to pick up when [relative's] not well or not functioning as [relative]normally does." However, one relative commented about concerns they had about staff response, saying staff had not recognised their relative was becoming unwell and, "Played down," their concerns. They told us their relative was subsequently admitted to hospital.

People and their relatives gave mixed feedback about the care and support provided by staff. They told us they felt comfortable permanent staff knew how to meet their care and support needs but expressed concerns about non-permanent staff. Comments included, "It depends on the staff. Permanent staff know [person] and what [person] likes and dislikes and treat [person] well. It's not the same when it's other staff; they tend to fall a bit short. They don't know [person's] particular dislikes. For example, [person] does not like any one to touch [person]; when they did [person] got upset", "There's no consistency. Trouble is there is a lot of different staff and they're not all keyed in the same and don't all do the things that others will do", "Depends who you get", "It's a fine service, they're very good with [person]," and, "They look after [person] very well as [person] is quite poorly."

At Wagtail Close respite unit, people used the service provided at the restaurant at Eden Gardens, situated next door. There was a kitchenette area at Wagtail Close for people to make drinks and snacks, as well as people having their own kitchenette areas in their apartments. Staff told us they gave people choices from the menu and they assisted people to the restaurant or staff collected meals on trays to take to Wagtail Close. People told us, "Food there is okay. It's got better; they've changed the menus", "I tend not to go up there for food. Half past four's a bit early, and it can be cold getting there. And if I'm up until 11, it's a long time between then and bedtime," and, "Teatime, there's a set menu. There's five choices to choose from. That's good. It has changed slightly, because I do get bored of the same food." We spoke with the chef who was employed by an outside agency. They told us staff at Wagtail Close communicated any specific dietary needs of people who were using the service and they maintained a list of those on special diets. They offered alternatives to those who did not want what was on the menu, such as jacket potatoes, omelettes and soup.

Menus were on a four weekly cycle and changed seasonally.

Within the domiciliary care service, we received mostly positive feedback from people and their relatives where staff assisted people with their nutritional needs. People who used the service within the extra care services had the additional option of an on-site restaurant for their meals. Some people told us they were happy with the support provided and told us, "The carers make me a cold breakfast and I take myself down to the dining room for lunch. It's a nice place and generally the meals are very good. I then make my own tea", "[Person] cooks [person's] own meals, breakfast and tea, but [person] does have [person's] lunch in the dining room. The food is exceptional, really good," and, "They take [person] down to the dining room for [person's] dinner. [Person] likes the company in there." However, one relative told us they were not happy with the nutritional support their relative had received when their relative was waiting for a GP to visit since they had not received a meal throughout the day.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack 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. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). In the case of domiciliary care agencies applications must be made to the Court of Protection.

We checked whether the service was working within the principles of the MCA and whether any conditions were being met. At the time of our inspection, no applications to deprive people of their liberty had been submitted to the local authority. However, the registered manager understood their legal responsibilities under the Act and staff had received training on MCA and DoLS.

People's capacity to consent to their care and support arrangements was assessed and we saw people's relatives and health professionals were involved in best interest decisions to help ensure people's rights were protected. However, we identified more information could have been embedded into each individual care plan about people's capacity to understand and consent to each individual plan of care. People and their relatives told us consent was sought during care and support and we observed this during our inspection.

Staff told us they had received the required training to provide effective care, including safe administration of medicines, safeguarding, food hygiene, MCA/DoLS, first aid, health and safety and infection control. They said training was a subject covered at supervision. For example, one staff member told us they had put their name forward to complete a qualification in dementia during their supervision and this was now taking place. We saw there was not a central list of training completed and each area of the service had their own training matrix in place, although these were not all updated at the time of inspection. This made it difficult to assess if all staff training was up to date. We concluded from speaking with the registered manager and information received after the inspection that most training was up to date or booked. However, we saw from the training matrix that 23 out of 29 staff at Wagtail Close appeared to be out of date with infection control training. Six out of 15 staff at Dove Court (extra care service where people receive personal care from the service) appeared to be out of date with moving and handling training and 11 out of 15 staff appeared to be out of date with the in-house medicines training. The registered manager gave us information about other training we had found to be out of date on the matrix which evidenced staff had attended this training.

We recommend the service takes action to maintain accurate and clear systems to ensure staff training is kept up to date.

Staff new to care were enrolled on the Care Certificate. This is a government-recognised programme to equip new care staff with the required skills to perform their role effectively. New staff were subject to an induction process which included familiarisation with systems and processes, relevant training and shadowing experienced staff for a number of shift, depending on their experience.

A structured supervision and annual appraisal system was in place. Staff received regular supervision from the unit managers, which covered topics such as tasks, safeguarding and person centred care. Staff we spoke with confirmed these took place and were an opportunity to discuss concerns, training and career development opportunities.

We saw staff assisted people to use technology to enhance their wellbeing and sense of social connection. One person utilised a voice-controlled computer and others used tablets and mobile phones. One of the apartments at Wagtail Close contained specially adapted 'rise and lower' kitchen units for the sink and hob to promote independence in these areas for wheelchair users.

Requires Improvement

Is the service caring?

Our findings

We received mixed comments about the care and support from care staff. Most people and their relatives told us most staff treated them with kindness and compassion. Comments included, "They're ok, nice people, caring people", "They're like friends; we have a laugh and a chat, know our names, offer help if we need anything", "I think the care is very good", "Staff are okay. I don't get on with all the staff, but each to their own. I do get on with most of them. I'm more close to certain staff than to others. They treat me okay, don't talk over me," and, "Staff treat me well. I'm not a hard person to get along with." However, other people told us some care staff were impolite and not as caring and supportive about their care needs as other staff members. One person told us, "Depends who you get...Some of the carers I know really well. Stuff like not putting pads on properly; on the whole, they're good...The carers do know me; I think that makes a difference." Another person commented, "Nice when [relative] is here, but not the same when [relative's] not." A relative expressed concerns about the care of their relative and told us, "The care and support is atrocious...I don't feel confident in the staff at all," and another relative commented, "It was alright at first but it's gone downhill...Don't get me wrong, some of the staff are really nice but I don't think they try enough with my [relative]." We checked and no formal complaint had been made to the service in relation to these concerns.

Staff we spoke with and those we observed during our inspection were caring and knew people well. Staff spoke about people warmly and were able to give examples about people's likes, dislikes and care needs. One relative told us, "My [relative's] settled in really well now. [Relative] knows most of the staff and they know [relative]."

Staff told us they respected people's privacy and dignity by ensuring doors and curtains were closed and people were covered up as much as possible when providing personal care. People also told us staff respected their dignity. One person commented, "I do get cold quite quick. When I've got out of the shower, they cover me over first while they clean the floor and then they come back. If anyone comes to the door, they ask me if I would like them to answer the door and if they would like me to let someone in. They ask people to come back in 20 minutes, or if it's the nurse, they'll ask her to wait until I'm ready." Another person told us, "They shut curtains and shut door. If anyone comes in, they make them hang around."

A person centred approach to care and support was evident. People were able to get up at a time that suited them, eat where they wished to, spend time where they wanted to and this was recorded in their care plan.

Some people told us they had been involved in the planning and review of their care. Comments included, "I ask for a yearly review of the care plan and I am kept informed," and, "They do review my care quite regularly and they always listen to me, and they're very good." However, other people said this had not happened. Comments included, "I used to be involved in [relative's] care plan but we have not had a review for three years now," and, "I have never seen [relative's] care plan or been invited to discuss it, I asked for a review in January and was told social services had to do it and I have not heard anything since."

We saw a clear emphasis was placed on enabling people to retain and regain their independence. For example, we saw staff supported one person who was registered blind to receive their medication in boxes with Braille writing on the side so they were able to understand the contents and when to take the medicine. This enabled the person to remain independent with taking their medication.

We looked at how the service worked within the principles of the Equality Act 2010 and in particular, how the service ensured people were not treated unfairly because of any characteristics that are protected under the legislation. We spoke with the registered manager about the protected characteristics of disability, race, religion and sexual orientation and they showed a good understanding of how they needed to act to ensure discrimination was not a feature of the service. For example, they explained that some staff members were allocated to visit people who they could speak with in their own language where possible. However, from speaking with people and their relatives we saw this did not always occur. One relative told us, "Care is ok but they don't meet my [relative's] cultural needs. [Relative] has no one to talk with in [relative's] own language which is Guajarati. It is not diverse enough for [relative] to be able to mix and [relative] is isolated; we provide [relative's] food so that is not a problem."

Requires Improvement

Is the service responsive?

Our findings

An assessment was completed prior to admission, which detailed any specialised needs including cultural, health, dietary, social or spiritual needs. However, we saw some people's care plans lacked detailed individualised information and the same phrases were often used in each person's file.

We saw that people had person centred care plans in place which took into account people's individual preferences. This assisted staff to have an understanding of the individual's care and support needs. However, we found information in some people's care records was contradictory. For example, one person's moving and handling risk assessment stated they mobilised with a 'three wheeled walker' but the moving and handling care plan stated they mobilised without aids. Another person's care plan told us they liked to sit in the bathroom and have a wash. However, their moving and handling care plan told us they only had a wash on the bed. This meant some people were at risk of not receiving the correct care and support from staff.

We concluded from our review of people's care records that clearer guidance was required for staff who supported people with their nutritional intake. For example, we looked at the care records of one person who was nutritionally at risk. We saw although they had a food and drink plan in place, this lacked detailed information to guide staff. The person's nutritional care plan detailed how small food should be cut up but the person had also been prescribed a thickener and the required consistency was not described in the care records. The same person was living with diabetes but this was not mentioned in their nutritional care plan and no information was present to guide staff about what foods the person should eat or avoid. Therefore, staff were not given clear direction about the actions needed to reduce the risk. We saw although the person's nutrition had been assessed by the GP, no referral had been sent to the speech and language team (SALT). We spoke with the registered manager who told us a referral would be made to the SALT team.

Another person's care records showed they required a low potassium diet. However, no guidance was present in their nutritional care plan about how staff could ensure this was achieved.

We saw in another person's care records they were registered blind. However, their food and drink care plan stated, 'Staff are to encourage me to choose what I would like to eat by showing me what is on offer. I like staff to plate up the lunch and show me what is available on the plate.' Due to the person's sight impairment we were concerned they were at risk of not getting the food they would like as staff had no guidance on other methods of communication to use. However, there was no evidence in the person's daily notes to suggest the person had not received a healthy and nutritious diet.

Reviews of people's care were regularly conducted. However, there was a lack of evidence in care records that the person or their family had been involved in the planning or review of their care. This was confirmed by some of the comments we received when speaking with people and/or their relatives.

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

We looked at how the service supported people at the end of their life to have a comfortable, dignified and pain-free death. The registered manager told us there was no-one the service supported who required this at the present time. They said plans would be put in place to record people's preferences and support people appropriately should the need arise.

The service had a complaints policy and procedure in place. Information on how to make a complaint was on display. The registered manager told us there had been no recent formal complaints from people who used the service or relatives.

We looked at how the service supported people in line with the Accessible Information Standard. The provider had developed an accessible information policy. We saw one person who was registered blind and profoundly deaf was supported by staff to attend a specialist centre every week. Another person who was unable to speak English was supported by staff who spoke their native tongue wherever possible. Another person was unable to read or write and staff took time to explain their care plan so they were involved at every stage.

We saw the service had received many written compliments over the last year. For example, we saw one comment from a family member which stated, 'I wish it thank all the staff at Dove Court for the constant care and love you have given to my [relative]. [Relative] loved [relative's] flat and enjoyed living there. [Relative] always felt safe.'

We saw appropriate equipment such as ceiling track hoists, electric baths and assisted shows were in use at Wagtail Close. These were serviced and used correctly although we discussed the use of a ceiling track hoist for one person to enable them to 'hover' over the toilet for specific medical reasons. The registered manager reviewed documentation about this and sent us information following the inspection that indicated this was agreed following a previous occupational therapy assessment. They agreed to arrange a review of this since the previous assessment had taken place a number of years ago. They confirmed this had taken place following our inspection and the provider moving and handling assessor confirmed the practice was still appropriate for the person's needs.

We saw people were supported to access a range of activities within the unit buildings as well as within the wider community, according to their preferences and wishes. For example, we saw regular social events such as musical events, parties and quiz evenings were held at the property next door to Wagtail Close and people were encouraged to attend these with support from staff. Staff at Wagtail Close also told us they offered other people one to one activities such as dominoes and board games.

Requires Improvement

Is the service well-led?

Our findings

At our last two inspections of Wagtail Close in January 2016 and December 2016/January 2017 we found the registered provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This regulation relates to the governance of the service. We had found the internal audit and quality assurance systems were not robust and had failed to identify the shortfalls in the service we found during the inspection process.

For example, at our inspection in January 2016 we found complaints were not being managed effectively and accident and incidents were not being reviewed and analysed for themes and trends. At our inspection in December 2016 and January 2017 we found although there were quality assurance systems in place designed to continually monitor and identified shortfalls in service provision, they were still not sufficiently robust and had not identified some of the concerns found at inspection. We found some risk assessments and care plans had not been updated and medicines were not always administered as prescribed.

At this inspection, we found continued concerns which had not been highlighted by the quality assurance systems. For example, although care records and risk assessments were audited, we found contradictory information in some of the care records we reviewed and information lacking in others, such as how staff supported people with specific needs. Financial audits had not highlighted the concerns we raised about some people's finances. Although we saw the registered manager took some immediate steps to rectify these concerns, if the quality assurance systems had been robust, these areas of concern would have been identified sooner and without us having to bring them to the attention of the registered manager.

Most people and relatives we spoke with said they were not aware of resident's/relatives' meetings where they could feedback about the quality of the service and any improvements. Comments included, "Never heard of any relatives meetings", "No, never had a relatives meeting", "I'm not sure about resident meetings but we do get a newsletter," and, We do have residents meetings; not often, though...when we do have them, people raise concerns."

Although some people told us they had received quality questionnaires or had staff visit with quality questionnaires, people told us they had not had feedback about the results of these, or knew if any actions had been taken as a result of their comments. The service used quality visitors who visited the service to speak with people who used the service to gain their views on whether they felt the service was safe, caring and responsive. The quality visitor also looked at the cleanliness of the building, staff interactions and whether people felt they were treated with dignity and respect. Completed surveys were then given to the registered manager to analysis and complete any actions. One person told us, "I've had a questionnaire but don't remember hearing anything about it afterwards," and another person commented, "The seniors come around with a question and answer machine once a month. It says things like 'do carers knock on the door', 'do they treat you with respect'. Don't know of any feedback afterwards. I think it goes back to [registered manager], but I'm not sure." One person commented, "No-one from Wagtail has asked. Haven't been down to see me for ages."

We concluded the service needed to improve engagement with people who used the service and relatives to ensure they felt involved with the service and that their views about the running of the service were listened to and actions taken as a result to improve the service. Lack of effective engagement was a concern which was raised throughout our discussions with people and their relatives.

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

People we spoke with told us they felt comfortable approaching staff or a member of the management team if they had any concerns and most people were aware of who the registered manager was. Comments included, "The new manager seems approachable", "Yes I know the manager at the moment", "I know the management very well and see them quite often," and, "If somebody said they were having a problem with a member of staff, then they would talk to [registered manager] or [locality manager]; [locality manager's] approachable as well. It gets sorted."

Staff told us morale was good at the service, staff worked well together and praised the registered manager and the management team, telling us they were approachable and supportive. Comments included, "Great team spirit; we help each other out. I feel very supported in my role; any problems, I'd go to my manager. [Registered manager] has supported me; really good, pleasant and easy to talk to", "I can't imagine being anywhere else. The staff you're working with are so lovely. It's new management. I get the support I need; I could go in and ask for support", "It's a good team spirit; one big family. I feel supported by the seniors. No problems. Managers are great; they're all really caring," and, "[Management team] are very supportive and have helped me."

We talked with the registered manager. They told us due to recent changes, with the service taking on the care and support of people at more properties, it was a large and complex service to manage effectively. They told us, "I have very good support from my manager...Think there's a lot of expectations. I'm only human. Sometimes it feels like crisis management. It's a challenge." We found the registered manager open and honest in their summation of the improvements required at the service and responsive to the feedback given during the inspection process.

We saw the service worked effectively with other agencies such as health care professionals and social care professionals. For example, we saw a written compliment had been received from a social care professional which said, 'A short email to say how pleased I have been with the planned care and attention from yourself and your staff team. My person who is in the taster flat has thrived within the environment; this is clearly due to the tenacity of staff and their endeavours to maintain independence. The updates and feedback from staff at my visits have proven very helpful. Keep it up.'

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes to assess, monitor and improve the service needed to be more robust. Robust systems were not always in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. Accurate, complete and contemporaneous care records for each service user were not always maintained. Feedback from relevant persons was not always sought or acted upon to continually evaluate and improve the service or communicated how this feedback been acted upon to improve the service. Regulation 17 (1) (2) (a) (b) (c) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning notice