1st Call Homecare Limited

1st Call Homecare Limited - 115 Beaumont Road

Inspection report

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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

The inspection took place on 14, 18, 21 May, 08 June and was announced.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community and in six extra care housing units across Plymouth. It provides a service to older adults who may have dementia or a sensory or physical disability.

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

Not everyone using the service receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

A registered manager was employed to manage the service locally. 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 owner, who was also the Nominated Individual was also involved in the day to day running of the service. Each extra care housing unit had a team leader in place who was responsible for the day to day running of the unit.

People often experienced calls that were too early or too late for their needs. They also weren't always informed of changes to call times and didn't always have consistent staff members. Staff told us they felt the organisation was short staffed and they or other staff were pressured to fulfil extra calls as a result.

Risk assessments were not always in place to guide staff how to reduce risks relating to people's health and social care needs. Staff identified people's changing health needs but it was not always clear whose responsibility it was to contact the relevant healthcare professional. People received their medicines safely from trained staff; however these were not always recorded or monitored in a safe way.

Safe recruitment procedures were in place, however when new staff shadowed experienced in people's homes, people had not been told the staff member may not have an up to date DBS in place.

People's care plans did not include information about how they liked their care delivering. Staff told us care plans were not always up to date. People preferred methods of communication had not always been sought. However, where these were known by staff they were respected.

Where staff had got to know people well, they used their knowledge of them to ensure their wellbeing was

promoted and their preferred routine, likes and dislikes were respected. However this information was not always included in people's care plans. Information about people's gender, sexuality or communication needs had not been sought by the service. This meant staff may not have been protecting people's human rights in relation to these characteristics.

The registered manager and provider had not ensured that when people lacked capacity, a mental capacity assessment was completed. This meant their rights may not have been respected.

The registered manager and provider had not ensured there was an effective quality assurance system in place that enabled them to have a clear overview of all aspects of the service. Where senior staff checked aspects of the service or information on the quality of the service was collected from people, there was no clear plan to improve any areas of concern.

People told us staff were caring and treated them with respect. Staff gave examples of how they supported people to maintain their independence and protect their privacy.

People told us they felt safe using the service and that staff followed safe infection control procedures. Staff received regular training including how to recognise and report abuse.

We made a recommendation about ensuring staff were trained to meet people's specific needs.

We found breaches of regulation. 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.

People did not always get their calls at the right time and were not always told of changes.

Staff told us there were not enough staff to fulfil all calls on time.

People did not always have risk assessments in place covering all risks relating to their health or social care needs.

Staff followed safe infection control procedures.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider had not understood or fulfilled their responsibilities under the Mental Capacity Act 2005 (MCA).

People received support from staff who received regular training but this did not cover everyone's specific needs.

Staff received regular supervisions and spot checks of their work.

Staff knew people as individuals and promoted independence whenever possible.

Is the service caring?

Good

The service remains Good

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always reflect all people's up to date needs and did not contain information about people's preferred routines.

People were offered choice.

People were able to receive information in a format that was suitable for their needs.

People knew how to make a complaint and raise any concerns.

Is the service well-led?

Requires Improvement 

The service was not always well led.

The registered manager and provider had not monitored the overall quality of the service to ensure improvements were made.

Where information of concern had been identified, there was no plan to show how improvements would be made.

Learning was not always implemented as a result of complaints or incidents.

The registered manager and provider were not always open and honest during the inspection.

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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.

The inspection activity started on 14 May and ended on 08 June 2018. It included visits to people living both in the community and in the extra care housing units. Phone calls were made to people who use the service, professionals who know the service and staff who work at the service. We visited the office location on 14, 18, 21 May to see the manager, owner and office staff; and to review records, policies and procedures.

During the inspection we visited 14 people and 6 friends or relatives. We reviewed 18 people's records in detail. We also spoke with 19 staff members, a social worker and a district nurse and reviewed 5 personnel records and the training records for all staff. Other records we looked at included the records held within the service to show how the registered manager reviewed the quality of the service. This included a questionnaires to people who live at the service, minutes of meetings and policies and procedures.

We also spoke by phone with 10 people who use the service, 5 relatives, six staff members, a GP and a district nurse.

The inspection was carried out by three adult social care inspectors and an expert by experience.
An expert by experience is a person who has personal experience of using or caring for someone who uses a similar service.

Prior to the inspection we reviewed the records held on the service. This included the Provider Information Return (PIR) which 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. We also reviewed notifications. Notifications are

specific events registered people have to tell us about by law.

Requires Improvement

Is the service safe?

Our findings

There were not always sufficient numbers of staff available to attend people's calls at their allocated times. One person told us, "It's not the same when they are short staffed". Staff explained this often resulted in calls being late. Comments included, "We're often short staffed" and "Late calls do happen because they don't have the staff." At four of the extra care housing units, no concerns were raised about staffing levels. However, people and staff told us they felt two of the units were short staffed. People told us, "They are always short staffed", "If we have an emergency, and we often do, then they're left with having to visit the emergency" and "At the weekends sometimes we do not get the full amount of time." Staff confirmed, "It works when we there are a full selection of staff but not now. It is stressful."

People and staff raised concerns about the times of people's calls. People told us staff did not often miss calls but they were not always at the planned time. Comments included, "It's just timing that's a problem", "A couple of times they have been so late in the evening that [….] has gone to bed, so I phone them and tell them not to bother" and "When they arrive late, it's nearly lunchtime by then and too late for our tablets." One staff member told us, "I was sent into one person one and a half hours earlier than their allocated time, to put them to bed. That's a long time to be in bed until the carers come the next morning".

Staff confirmed they did not always manage to provide people's visits at the correct time, they felt this was partly because they were not allocated travel time between calls. Comments included, "It's difficult to complete the allocated call time and at the correct time especially when you're not familiar with the area or client" and "I try not to be late for the calls but am late two or three times per morning. If I raise a concern with the office, their response is, 'Sorry, there's nothing I can do about it.'"

People felt rushed by staff. Comments included, "They are supposed to be here for 30 minutes but only do about 10 minutes", "They have to rush. I just have to put up with it", "From time to time they are rushed off their feet." One staff member explained, "I always stay the time. I haven't got time to sit and chat though." A healthcare professional who knew one of the extra care housing units well, told us they could tell staff were stretched when they visited.

Sometimes people were told when their visit time was going to be changed, but this was not always the case. One person explained, "They very rarely let me know when they are going to be late", and "Sometimes I have to ring and ask where the carer is," and "1st Call are supposed to phone if they are late but never do. There have been a couple of times when they have not turned up at all." One staff member commented, "They brought forwards one call I attended, from 8 am to 7.15am and didn't let the person know. Newer people experience this regularly." The provider told us, "Sometimes the office staff are busy re booking calls and forget to alert people about the change in call time." There was no clear monitoring of people's call times to identify how often they were late and how frequently they were not advised the call would be late.

Overall, people confirmed the correct number of staff always attended calls. For example, if two members of staff were needed to support someone to move, two always attended. However we received concerns from people living in two of the extra care housing units, who needed help to move. They told us they had been

left on the toilet or in the shower after they had finished, because the second member of staff had left to provide care to someone else. One of the people's relatives explained, "Mum gets tearful because she's got things to do. She feels let down." The registered manager told us, following these concerns, that this was due to short staffing because of staff sickness. They confirmed they had, "Rearranged the runs to facilitate the required duration of the visits are covered."

People did not always have their calls fulfilled by the same staff. This meant staff were not always able to get to know people well. One relative told us, "Mum receives personal care but is having different staff. She's having strangers nearly every week. I wouldn't want that." A staff member confirmed, "The clients are not getting consistent carers. People with dementia need consistency so staff can pick up on any concerns."

The provider had not ensured there were sufficient staff to ensure people received their support at the agreed time. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had some risk assessments in place, for example relating to support to move, but these were the same for each person, so did not reflect individual risks. Where people had risks relating to their health or support needs these had not always been assessed, or guidance provided to staff about how to reduce the risks to people. For example, one person was described in their records as prone to overbalance and poor coordination. The person told us, "They give me a shower and help me to get dressed and give me breakfast. I have bad balance problems. They keep me safe and walk down the stairs in front of me but I worry I will fall on them and hurt them." There was no risk assessment in place to guide staff how to reduce the risk to the person or themselves.

People were not always supported by a service that acted promptly to learn from incidents. For example, one person was at risk of falling if they tried to answer their door. A staff member who attended this person's call had not been made aware of this information, and the person fell trying to answer the door. The person's family raised this issue with the office but on a second call, the staff member attending still had not been told this information and rang the bell again. The registered manager confirmed the correct information had not been shared with the staff members attending the call.

The provider had not ensured all risks to the health and safety of service users were assessed. The provider had not always taken action to mitigate risks to service users. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received training on medicines administration and people told us they received their medicines on time. However, Medicines Administration Records (MARs) at two of the extra care housing units were not completed in a way that reduced risks or mistakes. For example, staff had not always signed, or had checked MARs that they had handwritten and they had not always signed to say they had administered medicines. MARs were not checked by the provider to monitor whether staff were administering people's medicines in line with their prescription. This increased the risk of medicines errors or changes to people's needs not being identified.

People's care plans did not describe how people liked to be supported to take their medicines and people's risk assessments relating to medicines were not personalised. Staff did not always record if someone refused their medicine. This meant staff did not have information to provide individualised care, mitigate risks and identify any changes in people's needs.

The provider had not ensured medicines were monitored and recorded safely. This is a breach of Regulation

12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff who were recruited safely. Recruitment practices were in place and records showed appropriate checks were undertaken to help ensure the right staff were employed to keep people safe. New staff were enabled to attend shadow shifts with existing staff before they had a DBS check in place. However, there was no process in place detailing how people they visited would be protected. People were not alerted to the fact that the new staff member did not have a DBS check. During the inspection the provider updated their procedure to include further checks on new staff before they were enabled to shadow.

People told us they felt safe. People's safety was promoted by staff who understood how to help people feel safe at home. Support plans provided details for staff about what had been agreed with the individual about staff entering their home. Comments included, "I feel very safe with the carers and they check if I want anything before they leave". A staff member told us, "We always offer to lock people's doors before we leave and make them aware it's safer to do that."

People were protected by staff who had an awareness and understanding of signs of possible abuse. Staff received safeguarding training and knew who to contact externally should they feel that their concerns had not been dealt with appropriately. For example, the local authority or the police.

People were protected from the spread of infection by staff who had received infection control training. People and staff confirmed they had the correct equipment available to use, such as gloves and aprons, and always used them.

Requires Improvement

Is the service effective?

Our findings

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). The 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. Most people being supported by the service had the capacity to make their own decisions. However, where people did not have capacity to make certain decision, there was no mental capacity assessment in place or detail about how this affected the way staff needed to support the person. This meant their rights may not have always been protected.

Staff had received training on mental capacity, however the provider told us, "It's not within our remit to assess people's capacity." This showed they did not understand the principles of the MCA and had not fulfilled their responsibilities under it. People told us staff always asked for their consent before commencing any care tasks.

Decisions were made for people even though an assessment of their mental capacity had not been completed. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff members understood which people required support to report health concerns. One person confirmed, "I'm happy to discuss anything with staff and they put it in the notes if I'm not feeling too well and if necessary they will call the doctor." However it wasn't always clear which staff would contact the relevant professional about health concerns. Office staff told us, "Care staff need to contact GPs for people, as they know what is happening." However, care staff told us they didn't have time to contact people's GPs.

Some people were supported by staff to monitor their health. One person living in an extra care housing unit told us, "If I have a low blood sugar they come back and re-do the test and give me sugar, bread, butter, jam. I get wonderful care." A healthcare professional who knew one of the extra care housing units well told us they had trained staff in diabetic and PEG care and staff took care of these aspects well.

Staff told us they communicated with each other and external professionals to help ensure people's needs were met. Staff who worked in the community alerted the office of any changes, so other staff could be updated. A healthcare professional reported that staff listened to and followed their advice and alerted them of any concerns.

When people required support to prepare food and drink, staff knew people's dietary likes, dislikes and needs However, these were not always reflected in people's care plans or risk assessments. This meant their preferences may not have been known consistently by all staff.

People gave positive feedback about staff member's skills and knowledge. Comments included, "The staff

are first class", "Staff are brilliant, absolutely brill. The staff go over the top do extra things for us" and "They are brilliant and I get on with them all. I can't say enough good about them". A relative added, "One (staff member) comes and says 'Hello darling' and they have a laugh together! It brings them out and they are very happy."

People's care plans clearly described who they were, what their background was and some of their likes and dislikes. Staff we spoke with knew the people they cared for and were able to tell us about individuals' likes and dislikes. This helped staff understand people as a whole rather than just their care needs.

New members of staff completed an induction programme, which included training and shadowing shifts. This included meeting people as well as how to use any equipment. One staff member told us, "Shadowing shifts were really good and the induction was good." Staff confirmed they were asked if they felt confident to work alone before they were put on the rota.

Staff received regular training. One staff member told us, "The training is very good." Some staff received training, such as catheter or diabetic care, from healthcare professionals to enable them to support people effectively. However, one of the extra care housing units was a specialist service for people with a visual impairment and staff told us they had not received formal training in this area.

We recommend the provider reviews training to ensure staff supporting people with specific needs have received training in best practice.

Staff told us they received regular face to face supervisions as well as spot checks during people's calls and an annual appraisal. These enabled them to discuss any training needs or concerns they had and receive feedback about their work. People using the service were also contacted for their views of staff members who supported them. This helped ensure any problems were identified and acted upon.

Good

Is the service caring?

Our findings

People told us they were happy with the care they received. Comments included, "Staff are lovely. They do their best", "I'm satisfied. They are nice girls and ladies", "Excellent care" and "They're absolutely fantastic. They're just there for me." A healthcare professional who knew one of the extra care housing units well told us, staff were always helpful and caring.

People told us staff treated them with kindness and respect. Comments included, "You can't fault the staff they are all lovely, and they treat you with respect" and "Staff are always polite and respectful."
A relatives explained, "They treat [...] with respect and dignity and chat to them all the time."

Staff told us people were encouraged to maintain their independence and care plans identified what a person could do for themselves and what they needed support with. Staff gave examples of how they encouraged people's independence. One staff member explained, "Some people say they can't but if we say we'll do it together, then they will. It's about encouragement."

People were supported by staff members who understood the importance of building trust and rapport with people. One person told us, "[Staff member] is so cheerful and no matter how I am feeling, they will make me feel better. They always come in and shake my hand and make me laugh."

The PIR stated "An Equality and Human Rights Policy, and Equality and Human Rights training give carers the tools to make sure the service users they are supporting participate in decisions of care they are receiving, that the service user has been heard and been given choice." However, an assessment form completed about people before they started to use the service did not ask information about people's communication needs, gender or sexuality. This meant staff would not have been aware of people's protected characteristics or how these might affect the way they preferred their care to be delivered. By the end of the inspection, the registered manager had ensured this was in place so any related support needs would be known to staff.

People were supported by staff who promoted their wellbeing and acted as their advocates, when needed. One staff member told us, "If someone had a problem with anything, I'd help them find the right person to contact about it." Where staff knew people well, they were able to describe things that would affect people's wellbeing. Some people's care plans directed staff to 'check people's wellbeing'; however there was not always further information about what this meant for each individual. The registered manager told us this would be included in more detail in the future.

People told us their privacy and dignity was respected and staff informed us of various ways people were supported to have the privacy they needed. Personal records were stored securely and there were systems in place to help ensure confidentiality was maintained.

Requires Improvement

Is the service responsive?

Our findings

People had care plans in place but these did not always include important information about their health, needs or preferences. The PIR stated, "A detailed care needs assessment is completed with the involvement of the service user and family/representatives. We have information on service user's preferred times and their preferences on how they would like their care provided." However, one person was registered blind and could only see the shapes of objects; they also used a wheelchair. A staff member told us, "You have to make sure everything goes back in the right places." They also explained the importance of placing the person's wheelchair in the correct place in the bathroom so they could transfer themselves safely to the shower. None of this information was included in their care plan.

People's care plans outlined the care they required, but did not guide staff on how people liked to be supported with these tasks. Staff told us, "People's preferences are not always requested before they start the service. When people tell us what they like and don't like, that is recorded in the log book not in the care plan", "It may be a shower but people may want to get dressed somewhere else or have their curtains pulled a certain way" and "I write people's routines in detail in the log book. If I go on holiday, I write out people's preferences, for example, what days they like a shower and how they like their coffee. It doesn't say in the care plan." This meant staff members might not be consistent in the way they delivered people's care. One person confirmed staff did not meet their needs in a consistent way saying, "Some are very accommodating. They try to accommodate me in my wishes. It varies from carer to carer".

The PIR stated, "We explain the principles of person centred care and the importance of shared decision making which will help carers to provide individualised care to service users to improve their quality of life." People told us staff were responsive to their changing needs. However, care plans did not always reflect this ethos. People's care plans often contained identical detail to other people's care plans rather than individualised information which would enable staff to provide person centred care. One person's care plan stated someone else's name in parts.

The provider had not ensured people's care was designed to reflect their preferences and their individual needs. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans were not always up to date. There was a process in place to help ensure they were reviewed regularly and updated when any changes arose. However, this process was not always effective. Staff told us, "Some care plans are up to date but there's only one person doing them" and "Reasonably up to date, but not always." This meant staff may not have been aware of a person's up to date needs when they attended their call.

The provider had not ensured records of service user's needs were complete and up to date. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives told us staff were responsive to people's needs. Comments included, "They have made

a difference to my life", "They're really good. As dad deteriorates they are very accommodating to his changing needs" and "They are very good and do everything I want".

People told us staff offered them choices. For example one person told us, "I'm asked whether I want a bath, a shower or a wash down." A staff member confirmed, "It's their house and their choice. You try to promote different choices."

The Accessible information Standard was met by the provider. The accessible Information Standard is a framework put in place making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. One of the extra care housing units was designed for people with a visual impairment and information was available in braille, audio or different fonts. Another extra care housing unit supported someone to communicate using an alphabet chart as this was their preference. Their care plan included details of what different signs meant, to aid communication between them and the staff team. Information about people's communication needs had not routinely been been sought before they started using the service. However, during the inspection the registered manager added this to the information staff collected to help ensure people's needs known to staff.

The service had a policy and procedure in place for dealing with any concerns or complaints. People and those who mattered to them knew who to contact if they needed to raise a concern or make a complaint. Complaints had been responded to in line with the policy.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in post who had overall responsibility for the service. The provider also worked from the same office. The registered manager was supported by team leaders who were responsible for the day to day running of the extra care housing units. However, people receiving care in the community said they did not know who the registered manager was.

The provider had not established an effective system to monitor the quality of the service. This meant concerns identified during the inspection, for example regarding people's call times, staffing levels and information included in people's care plans and risk assessments had not all been highlighted or acted upon effectively to improve the service. The PIR stated, "Quality assurance is achieved via questionnaires to the service users and families and also from the supervisions of the staff. This has been a successful approach and see no need to change this practice." However, during the inspection, people and staff reported improvements were required to the service.

The Provider's statement of purpose included the aim, "To focus on the service user, meet assessed need, ensure we are fit for purpose." However, systems were not in place to check whether this aim was met consistently across the organisation. People had been sent quality assurance questionnaires about the service they received. When negative comments had been made, records did not show that action had always been taken to improve the person's experience. A previous questionnaire had identified that people 'being kept informed of changes', was an area of improvement. Recent results showed satisfaction in this area had dropped even further. The concerns had been identified and discussed at staff meetings in May 2017 and in January 2018. However, no action plan to ensure how this would improve had been developed. This inspection identified the same concerns were ongoing and there remained no clear plan place detailing how the provider would ensure this was addressed. There was no evidence call times were being monitored by the registered manager or the provider to ensure improvements were made.

Information was not always used to drive improvement. Incidents and complaints were recorded and acted upon, however the registered manager and provider did not review these to identify if there were any themes that could be used to improve the service in the future. The PIR stated recent complaints had mostly concerned, "Changes to times of visit or a carer change." It added, "We are encouraging improved communication between the office and service users to keep them informed of changes." However, there was no evidence that changes made as a result of these or other complaints had been monitored by the registered manager or provider to ensure they had been effective.

Overall, staff told us they felt appreciated by their immediate manager. One staff member explained, "They told me I was an excellent worker and a valued carer. It makes you feel appreciated." However, others told us they did not feel there was a positive, supportive culture in the organisation. Staff told us that they, and particularly new staff members, were regularly pressured to work extra hours as there were not enough staff to cover all calls. Comments included, "I'm being harassed constantly to do extra calls. The rotas are changing nearly every day. There is no continuity" and "The new ones often get a lot of changes, back to back calls in different areas with no travel time." When we discussed this with the provider, they told us they

were unaware of this. This showed their quality assurance process had not been effective.

Where systems were in place to monitor the quality of the service, the registered manager and provider did not always have oversight of them. The PIR explained, "All staff training is focused on being person centred and shows staff how to effectively deliver person centred care. We explain the principles of person centred care and the importance of shared decision making which will help carers to provide individualised care to service users to improve their quality of life. Regular supervisions and spot checks take place to ensure staff are following these principles together with meetings with the service user to continually check they are happy with their care package and the way it is being delivered." These checks were mostly carried out by senior staff members but there was no evidence the registered manager or provider had an overview of these activities to ensure quality was maintained. For example, people and staff confirmed team leaders in the extra care housing units completed spot checks and visited people to check on and ask about their care. A team leader from one of the extra care housing units told us, "Somebody from the organisation comes perhaps 6 monthly". They also told us there was no record or outcomes recorded from the visits to help improve the service, though.

Learning was not always used to improve the service. The previous inspection had identified gaps in people's risk assessments, care plans, medicines management and quality assurance systems, however despite the provider (who was the registered manager at the time) providing us with assurances that they would improve these areas, gaps still remained.

The registered manager and provider were not always open and honest during the inspection. Prior to the inspection, we asked the registered manager to tell people we might contact them by phone and to ensure staff members and people using the service received information about how to contribute to the inspection process. During the inspection, the registered manager confirmed this had happened however, none of the staff members we spoke to knew about the inspection. One staff member told us, "I was aware of the inspection through the grapevine but I haven't received information about it." Nobody using the service, who we contacted by phone, was expecting our call.

During the inspection we were given records which stated why two people's calls had been significantly earlier or later than their planned time. We were told that healthcare professionals had requested the times were changed to suit appointments and that one was due to a faulty lock on someone's door. However, when we spoke to the relevant professionals and people's relatives, we were told there were no reasons why the calls on these days were not at the correct times. This did not reflect the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

The provider had not ensured they had effective systems to monitor the, culture and quality of the service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had not notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations. Following a fall, one person's son reported to the registered manager that they had fractured their ribs. However, we had not been notified of this incident.

The provider had failed to notify us of all significant events in line with their legal obligations. This is a breach of Regulation 18 of the Registration Regulations 2009.

Health care professionals who had involvement with the extra care housing units confirmed to us, communication was good. One healthcare professionals had recommended one of the units to their father

to live in.

Staff working in the extra care housing units gave positive feedback about team leaders, who managed the units on a day to day basis. Comments included, (The team leader) is really responsive and knows the clients" and "(The team leader) is brilliant. They go above and beyond for service users and is happy to work on the floor." Staff were also positive about their job roles and the culture within the units. Comments included, "I love it there. It's a lovely atmosphere there" and "There's a good team who work well together."

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify us of all significant events in line with their legal obligations.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured people's care was designed to reflect their preferences and their individual needs.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Decisions were made for people without clear evidence that they could not make the decision for themselves.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured all risks to the health and safety of service users were assessed The provider had not always taken action to mitigate risks to service users. The provider had not ensured medicines were monitored and recorded safely.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured medicines were monitored and recorded safely. The provider had not ensured they had effective systems monitor the quality of the service. They had not monitored work delegated to other staff and had not used information received to improve the quality of the service. The provider was not always open and honest. The provider had not ensured records of service user's needs were up to date.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were sufficient staff to ensure people's received their support at the agreed time.