Carewatch Care Services Limited

Carewatch (Colebrook House)

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

Summary of findings

Overall summary

About the service: Carewatch (Colebrook House) is a domiciliary care agency. It provides personal care to people in their own houses and flats. It provides a service for up to 102 older adults. At the time of this inspection 88 people were being supported with personal care.

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

People's experience of using this service:
- People did not always experience a consistent high quality, person-centred care and support.
- People were put at risk of receiving unsafe care and treatment because appropriate assessments were not always carried out with management plans for their needs to be met.
- People were not always supported with their medicines safely.
- People were not always supported at the time and duration planned for and sufficient staff were not always available to meet people's needs.
- People's privacy and dignity was not always respected.
- People said the service was not always caring and there was a language barrier between them and staff.
- People were provided with choice daily but they were not always involved in planning their care and support needs.
- The culture in the service was poor and staff teams did not consistently work together to deliver an effective service.
- The service was not consistently well-led and the management team lacked clear oversight and knowledge of how the service should be delivered.
- The systems in place to assess, monitor the quality of the service and drive improvement was ineffective.
- We have made a recommendation about working within the principles of the Mental Capacity Act (MCA) 2005 and the handling of complaints.
- The provider had policies and procedures in place for safeguarding adults; however staff were not confident all abuse would be taken seriously.
- Staff received induction, training, supervision and appraisals but they did not feel supported in their role.
- People were supported to eat and drink for their health and well-being.
- People's independence was promoted.
- People were supported to access healthcare services and the staff team worked in partnership with key professionals to provide joined-up care.

Rating at last inspection: This is our first inspection of the service since registering with us on 27 February 2018.

Why we inspected: This inspection was part of our routine scheduled plan of visiting services to check the safety and quality of the care people received.

Enforcement: Action we told the provider to take (refer to end of full report)

Follow up: We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

Carewatch (Colebrook House)

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
This inspection was carried out by two inspectors and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their areas of expertise are in older people and dementia care.

Service and service type: Carewatch (Colebrook House) provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is bought or rented, and is the occupants' 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
This inspection was announced. We gave the service 48 hours' notice of the inspection visit because we needed to be sure that the registered manager would be in.

Inspection site visit activity started on 20 February 2019 and ended on 21 February 2019. We visited the office

location on both days to see the registered manager, office and care staff; and to review care records and policies and procedures. We also spoke with people using the service.

What we did:

Before the inspection we looked at all the information we had about the service. This information included statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. Due to technical problems, the provider was not able to complete a Provider Information Return. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgement in this report. We also sought feedback from the local authority that commissioned the service and other health and social care professionals. We used all this information to plan our inspection.

During the inspection, we spoke with 12 people and ten relatives to gather their views about the service. We spoke with the registered manager, a scheme manager, a quality service improvement manager, a quality officer and eight care staff. We reviewed eight care plans, risk assessments and medicines records. We reviewed ten staff files including staff recruitment, training and supervision records. We also looked at records used in managing the service including policies and procedures, accidents and incident records, complaints, staff rotas, call bell logs, audits and quality assurance reports, surveys and minutes of meetings.

Requires Improvement

Is the service safe?

Our findings

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

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Learning lessons when things go wrong; Assessing risk, safety monitoring and management

● People were at risk of avoidable harm. Records showed there had been multiple falls at the service. For example, there had been 18 falls between November 2018 and February 2019. The service had not carried out any analysis of these falls to identify any trends to improve the quality of service provided and to minimise the number of falls occurring. People had falls risk assessment in place, however the high number of falls in the service demonstrated these were ineffective. The system in place for recording accidents and incidents included a section to include 'learning outcomes'. The learning for all the accident and incident records we reviewed had not been completed.

● The knowledge of both management and care staff about falls prevention was poor and staff had not received falls prevention and awareness training despite the concerns of falls at the service.

● Risks to people were not always identified, assessed and had appropriate management plans to manage risks safely. For example, one person's care plan stated, "[person name] has feeling of loneliness and sadness and having suicidal thoughts or thoughts about harming themselves." Their care or risk management plan did not include guidance for staff on how to support the person with their mental health needs and how to manage this risk safely. Another person was assessed as requiring support from staff with their monies. However, on their risk assessment, there was no guidance provided which detailed what measures were in place to minimise risk of actual or alleged theft or loss. This section was left blank.

A failure to ensure risks associated with people's care were assessed and plans implemented and delivered to mitigate the risks was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● People's medicines were not always managed safely. Medicines were stored in people's own flats. Medicines administration records were used to record the support people received with their medicines. The MARs included a list of medicines, dosage and frequency. Gaps in MARs had been identified during the provider's own medicines audits system.

● Where people were prescribed 'as required' medicines (PRN) such as painkillers or laxatives, PRN protocols were in place and provided staff guidance on the support to provide, the signs to look out for and when this medicine could be administered.

● However, we found areas where medicines were not being managed safely. A relative told us, "They [staff] are meant to apply cream on (named body part) but they don't do it...when I look in the book, it sometimes says he doesn't want anything, but he needs it…. They should try harder to do it." One person told us, "The medicine was not given but the log books say that they have whilst the medicine is still in the dossett box."

● A list of people's medicines and reasons why they were taking these medicines was not recorded in care

plans.
● The level of support each person required to take their medicines was recorded in their care plan as level 1 (prompting). We found that this information was not always accurate as some people were unable to self-medicate which put them at risk of receiving unsafe levels of support with their medicines.
● Two people we visited in their flats had medicines administered by district nurses stored together with those administered by care staff and listed on the MARs. This puts people at risk of receiving medicines from care staff instead of district nurses. A staff member told us, "Medicines given by the district nurses are recorded on the MARs which confuses staff."

A failure to ensure the proper and safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We raised these issues with the registered manager and they told us the service had been liaising with the various pharmacies that supplied people's medicines to ensure there was consistency which would promote safe management of medicines.

Staffing and recruitment
● The registered manager told us staffing levels were planned based on people's assessed needs. A staffing rota we reviewed showed the number of staff on shift matched with the numbers planned for. To promote consistency, the service recently stopped using agency staff.
● However, we had mixed feedback from people and their relatives regarding staffing levels. One person told us, "Carers [staff] are not always on time, they come to see me at 9pm when they should be here at 8pm… Sometimes when you press the bell, carers can take a long time to attend to you especially at weekends." Another person told us, "They [staff] come on time most of the time… but weekends are a bit of a problem, we don't have the same level of care." A relative told us, "[My loved one] often has no staff for her lunch call and they have to wait until about 3 o'clock for their lunch".
● Records showed that people did not always receive care and support at the time and duration it was planned for. For example, the local authority care and support plan stated that a person needed to be supported in the morning for 8.30am to 9.15 (45 minutes). However, the person's care plan stated the person was to be supported for 9.30 – 10.00am. This was an hour later and 15 minutes reduced from the allocated time determined by the local authority. The local authority care and support plan also showed that this person required 30 minutes for a tea time call. The care plans showed this had been reduced to 15 minutes and records showed that on occasions, staff had only stayed for 10 minutes for the tea time calls. Records also showed variation with times, staff had attended the calls on each day.
● Staffing levels had been recently increased for day shifts. However, staff told us that the staffing levels for night and weekend shifts were not always appropriate. "One person told us, "Staff never stay very long… Weekends are horrendous because there is no manager and you will not be able to find a carer [staff] in this whole building. Weekends are terrible!"
● Staff told us that the shift patterns were not appropriate. One member of staff commented, "Now we have these long shifts from 7am to 10pm… this is when staff make mistakes." A relative told us, "Some staff can be put on 14-hour shifts and one carer collapsed, the duties are so very unbalanced."

A failure to assess, monitor and mitigate risks related to the health and safety of people and staff was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We raised these issues with the registered manager. They said where there was a risk of people's needs not being met, they would liaise with the local authority that commissioned the service to ensure appropriate support was put in place for them.

● The provider followed safe recruitment practices and had ensured appropriate pre-employment checks were completed satisfactorily before staff were employed.

Systems and processes to safeguard people from the risk of abuse

● The provider had safeguarding policies and procedures in place. People and their relatives told us that they and their loved ones were safe and they did not have any concerns of abuse or discrimination. One person said, "[My loved one] leaves his door open and feels completely safe in the building."

● The registered manager knew of their responsibility to protect people in their care from abuse and had reported concerns of abuse to the local authority safeguarding team and CQC.

● Staff had completed safeguarding training and knew of the types of abuse that could occur, what to look out for and they would report any concerns of abuse to their managers. However, not all staff were confident that all management staff took concerns of abuse seriously and acted promptly to ensure people remained safe.

Preventing and controlling infection

● The provider had policies and procedures on infection control and prevention which provided staff guidance on how to prevent and minimise the spread of infections.

● All staff had completed infection control and food hygiene training. Staff told us they followed appropriate protocols including the use of personal protective equipment and washing of hands to prevent the spread of infections. People confirmed that staff wore gloves when supporting them.

Requires Improvement

Is the service effective?

Our findings

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

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were not always assessed to ensure the service was suitable and could meet their needs. People's using the service were transferred from a previous care provider. No one using the service could recall being reassessed when they transferred over to Carewatch (Colebrook House). Staff told us that people's needs were not being reassessed because they knew them and their care and risk management plans were being reviewed and updated without an assessment being carried out.
A failure to assess and meet the needs of people was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible".

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● The registered manager told us most people had capacity to make day-to-day decisions. Where people were found unable to make specific decisions for themselves, they carried out mental capacity assessments and with best interest meetings.
● People we spoke with confirmed they could make their own decisions and they had not experienced any restrictions or restraint. One person told us, "Staff are respectful and they ask for my consent."
● Where people were unable to make decisions for themselves, the service did not always work within the principles of MCA. For example, one person's care plan stated, "[person's name] has no capacity to understand the context of this assessment and make decision to be able to give their consent." The care plan stated their relative was responsible for making decisions about their finance and welfare but they did not have lasting power of attorney (LPA) in place. This person had signed their care plan despite them being unable to make a decision or give their consent. There was no capacity assessment in place and there was no evidence to show who was involved to make decisions in the person's best interest.

We recommend that the service consider current guidance on MCA 2005 and update their practice accordingly.

Staff support: induction, training, skills and experience

● We received mixed feedback from people and their relatives about staff skills and experience. A relative told us, "I think the carers know what they are doing when providing the appropriate care." However, other people said, "There is a bath on each floor and every time we ask for a bath they tell us staff are not trained." And "They won't use the oven so I presume they haven't been trained to." A relative told us, "[My loved one] asked for an egg sandwich but they didn't know how to make that."

● Despite this feedback, records showed that new staff completed a five-day induction programme in line with the Care Certificate which is the bench mark set for the induction standard of new care workers. New staff also shadow experienced members of staff, they were monitored, observed and found competent for the role.

● Staff told us they had completed all mandatory training which had been refreshed when due. However, they felt other training such as dementia, diabetes awareness and end of life care would be useful to help identify and support people's needs. A training matrix showed all staff had completed refresher mandatory training but we could not confirm what training courses were completed as the matrix did not state individual training programmes.

● The registered manager informed us that the provider was introducing a train-the-trainer system to ensure a dedicated trainer was available to staff at each scheme to support their development.

● Supervision records we reviewed showed that there was evidence of supervision and appraisals taking place. However, staff told us they did not always feel supported in their role.

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

● People were supported to eat and drink sufficient amounts for their health and wellbeing. One person told us, "If I don't feel like cooking, they bring me food from the canteen and they make me a cup of tea."

● Each scheme had an on-site restaurant managed by an independent company. People told us they enjoyed the food. One person said, "The [staff] support to bring me down to the canteen and the chef is very good."

● Some people could prepare their own food; however, where people required support, their relatives and staff supported them to purchase and prepare their food.

● Staff we spoke with knew the level of support each person required to eat and drink, they told us they would report any concerns of poor nutrition or dehydration to their managers or other health and social care professionals.

Supporting people to live healthier lives, access healthcare services and support: Staff working with other agencies to provide consistent, effective, timely care

● Each person using the service was registered with a GP. People received support from other healthcare professionals including physiotherapist, pharmacist, dieticians, occupational therapists and district nurses.

● At our inspection, we saw that the district nurse was visiting people. Staff told us a GP and optician visited to treat people in their homes.

● Staff worked in partnership with health and social care professionals to plan and deliver an effective service. Records showed that care staff liaised with other professionals when they had concerns about people's health and care.

● Each person had an emergency grab sheet which provided hospital and emergency teams relevant information about people's health, communication, likes and dislikes.

Requires Improvement

Is the service caring?

Our findings

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

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity

- People's privacy and dignity was not always respected, their rights to confidentiality was not always upheld. One person told us, "They ring the bell and come in and they respect me…But some of the carers sit in my flat and talk about other residents." A relative told us, I have complained about a couple of things that I think affect [My loved one's] dignity; he is constantly in a wet bed and they never change the bed."
- People said staff were not always kind and caring towards them. One person told us, "The carers [staff] are lovely people – never rude and always polite." A relative told us, "Staff are generally kind and respectful". However other people said, "Some of the carers [staff] are okay, good or bad… Some of them their attitude is bad and office staff are not good either, they don't come out of the office or speak to you." Another person said, "'I've found that staff have little initiative and have to be told what to do." A relative commented, "They [staff] come in unannounced and wake [my loved one] up and he doesn't like that."
- Staff told us the service was not always caring. Comments from staff included, "Not all the [care workers] are caring... No, they're not,"; "We are so busy writing thing up without caring." And "We need different managers, they don't really care as long as we document things."
- People and their relatives told us, there was a language barrier between them and the staff. Comments from relatives included, "Some [staff] have poor English and a strong accent and I could see [my loved one] getting frustrated."; "There's too many different nationalities and they all speak a different sort of English and [my loved one] doesn't always understand them," and "My [loved one] can't understand the staff who are not English and the staff can't understand my loved one. A staff member informed us, "I find it difficult understanding some of the girls [staff]." Another staff said, "There is a language barrier and with some of the [care worker's] attitude, they don't chat with people."

A failure to treat people with privacy, dignity and respect was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

- The registered manager told us they were making efforts to ensure they only employed staff that were kind and caring.
- Care plans included people's life histories (all about me), preferences and their likes and dislikes to help staff build relationship with them.
- People's diversities were promoted. For example, a priest visited the service to support people practice their faith. The service also supported married couples who lived together.
- People were supported to maintain their independence. One person told us, "I self-medicate, they only help me with personal care." A relative said, "The carers promote my [loved one's] independence – for example, he can still prepare and eat his own food and carers encourage this… I feel they have a good

relationship in knowing what he can and can't do." During the inspection, we observed some people accessing the local community on their own.

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

● Records showed that people and their relatives had been consulted about their care and support needs. The registered manager informed us people, their relatives and healthcare professionals were involved in reviewing people's care needs.

● Despite this, people told us they could not recollect when they were last consulted about their care and support needs. The registered manager told us they have not had regular review meetings for people in the last six months due to an overhaul of care plans and these meetings were held only when there were concerns.

● People were provided with choice so they could make day-to-day decisions about the clothes they wore, food they ate or activities they participated in. People we spoke with confirmed they were given choices, however, some people wished to have a bath instead of showers only. One person said, "I wish I could have a bath just once a once a month." Another said, "I will like a bath, but I can't get out of it."

● There were monthly tenants' meetings to gather people's feedback and a representative from the local authority also attended these meetings. People told us that staff took their views and feedback seriously during these meetings and acted upon them. One person said, "I told them about the names on the badges being too small and they were changed." People also wanted staff photographs displayed and this had been actioned.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● Each person had a care plan which provided staff guidance of how their needs should be met. These care plans included people's medical conditions, preferences and the level of support they required from staff.

● Despite this, not everyone knew they had a care plan in place and some people felt their needs were not always met. A relative told us, "[My loved one] is refusing personal care but they should be better at getting them to do things. They [The service] are not communicating with me and I think it's issues with the latest new manager who has only been here a few weeks." Another relative said, "I think the carers are doing only half the duties they should be doing"

● We could not find the care plans of two people we visited in their flats.

● At the time of this inspection, people's care plans were being rewritten because they were not up to date. We only looked at care plans that had been reviewed and were up-to-date. Despite this, we found that information in people's care plans was not always consistent with the care and support they received. For example, one person's care plan stated, "Medicines is locked in the staff office, and best interest decisions in place." Both staff and the management team confirmed no one's medicine was kept in the office. Under maintaining nutrition, another person's care plan stated, "[Person's name] is on a bolus percutaneous endoscopic gastrostomy (PEG) feeding regime. Requires two bolus feeds daily." Both staff and management team told us no one using the service received nutritional support through PEG feeding, therefore staff had not been trained. We found the person could eat independently and was being supported by district nurses to receive their medicines through a PEG tube. A PEG tube is feeding tube used to give food, fluids and medicines directly into the stomach by passing a thin tube through the skin and into the stomach.

● At the time of this inspection, staff were updating care plans. We found that the care plans were being updated without any re-assessment of people's needs and staff we spoke with confirmed this was the usual practice.

● People's communication needs were not always met. The Accessible Information Standard is a framework put in place from August 2016 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 person's care plan stated, "[Person's name] is blind and unable to read any correspondence. I need support with understanding written forms of communication." There was no further information on how their communication needs should be met. Another person's care plan stated, "To understand information, I require large formats." We could not find any evidence to demonstrate that information was presented in large prints where required and individual communication met.

A failure to assess and meet the needs of people was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● The provider had policies and procedures on how to make a complaint and this was displayed at the schemes.

● People and their relatives told us they knew how to make a complaint; however, their expectations of how complaints would be handled was low. One person said, "When you complain they don't come back to you, I asked for a carer not to be sent back and she didn't come back again." Another person said, "When I complain, I am not sure they take action or not." A relative told us, "When I complain, staff A will blame staff B and Staff B will blame staff C… I've raised many complaints about the caring issues, some are dealt with okay, but some I feel there is a cover up; in general, I feel things are left hanging in the air".

● A complaint logs we reviewed showed the service had received nine complaints since registering with CQC and these had been responded to appropriately.

We recommend the provider follow their policies and procedures for all complaints and adhere to best practice guidelines when handling complaints.

End of life care and support

● At the time of this inspection, no one using the service required end of life support. The registered manager told us where required, they would refer the person to appropriate healthcare professionals to ensure they were supported and their end of life wishes met.

Inadequate

Is the service well-led?

Our findings

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- There was lack of management oversight of the service in areas including accident and incidents, complaints, safeguarding and managing staff. Managers were not always proactive in identifying risks or trends and acting promptly to improve the service or prevent reoccurrences. For example, eight of nine complaints we reviewed had been upheld. However, the management team had not analysed or identified any trends and put in place appropriate management plans to improve the quality of the service.
- The systems and processes in place for assessing and monitoring the quality and safety of the service was not always effective. Various audits had been undertaken by care staff and the provider's quality team in areas including medicines, daily logs, staff files, training, finance and health and safety. However, monitoring systems did not identify all the issues we found at our inspection including risk assessments and care planning, staffing levels, management of medicines and consent to care and support.
- Where issues were identified, action plans were put in place but these were not completed robustly and were not necessarily improving the quality of the service. For example, care records included risk assessments for managing people's money; a section which stated, "detail what measures are in place to minimise risk of actual or alleged theft or loss" was left blank or uncompleted. Before our inspection, there had been allegations of theft or lost. Despite this, management had not taken appropriate actions to devise a robust system and to ensure people's money was handled safely to minimise this risk.
- The service did not always maintain records that were accurate, complete and up-to-date. For example, people's care plans were not always reflective of their current care needs. We also found that some records were being completed without staff reviewing or carrying out any monitoring checks. For example, daily medicine checks were being done by care staff, we found that office staff were completing their own medicines audits without checking people's medicine and MARs to ensure people were receiving their medicines as prescribed by healthcare professionals.
- At our inspection, information was not readily available and records were not always presented promptly when required. For example, managers and staff told us that call bells logs were analysed to check for response time and to take further action where required. However, staff could not find this record. A scheme manager told us they completed daily 'walk arounds' but there were no records to evidence this.
- Each person had a pendant (call bell) to use if they needed staff support. The 'Chubb' call bell system which most people were reliant on for support 'jammed' regularly. Staff told us that this occurred when so many people call at the same time and they would not be able to identify who had called or if the call was urgent or not. One person stated, "I have complained to them that I could be lying here dead or in desperate need of their help, and they wouldn't know."
- There was an organisational structure in place; however, staff roles, responsibilities and accountability

was unclear.
● We had mixed views from staff about the support they received from managers. Positive comments from staff included, "I find the managers fair" and "the managers are okay." However other staff told us they were unhappy about the culture of the service and felt unsupported in their role. Staff told us there were issues of favouritism, blame culture, workload and the inability to speak up in an open and transparent manner without being threatened. Some staff also told us they did not have the resources such as computers and the skill set or qualifications to complete certain tasks delegated to them. Staff told us they did not have confidence in their managers because they did not always take actions when concerns such as people's health conditions or staff behaviours were reported to them.

The failure to ensure effective systems and processes were established to monitor and assess the safety and quality of the service, drive improvement and maintain records securely was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● There was a registered manager in post. This was their first experience of being a registered manager or managing a service of this size. They had notified CQC of significant events that had occurred at the service.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility
● Managers were not always proactive and committed to provide a meaningful, high level person centred care.
● We had mixed views from people about managers of the service. One person told us, "I think that the new Managers here are listening and they seem to be talking to the carers more. They have started to do spot checks." Whilst others told us, "I find management very confusing… In a nutshell if I had to improve the service, I would improve everything" "I wouldn't recommend this service to anyone, because of lack of care and no continuity and just unprofessionalism".
● People and their relatives did not always know who the managers were. One person told us, "I don't know the managers but I have a nurse coming in." Staff told us that managers were not approachable and did not know people living at the schemes.
● Managers were not always proactive in empowering people to be involved and make decisions about their care and support needs and had not always liaised effectively with those important to them to ensure that the care and support provided was meeting their needs.
● Information was not always presented in formats that met individual needs. People with sensory impairment and those that required information to be presented in in other formats such as large prints or picture formats did not have access to information that met their individual needs.
● Managers knew of their responsibility under the duty of candour that they had to be open, honest and take responsibility when things went wrong. Staff told us when things went wrong, managers would not own up and take responsibility but rather blame other staff.
This was also a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The registered manager told us that people's views were sought through quarterly surveys and monthly meetings which occurred at both schemes. They said results from the surveys were analysed and discussed at staff meetings to drive improvement. We were not provided the results, analysis and action plans from these surveys; although requested. We saw individual surveys in people's care plans and we saw that people had raised issues such as staff punctuality and attitude. Minutes of staff meetings we reviewed showed

feedback from people were discussed at these meetings.

● People told us that any issues raised at monthly meetings were addressed. For example, the staff badges had staff names written in large fonts which enabled them to know the name of the staff member supporting them.
● Staff meetings were held monthly to cascade information. These meetings were not always effective in gathering staff views because staff told us their views were not taken seriously and acted upon to improve the quality of the service.

Working in partnership with others
● The service work in partnership with the local authority that commissioned them and other key organisations. The local authority initially commissioned three schemes with the provider but had to decommission one scheme so the other two schemes could be managed well. The local authority's quality monitoring team had carried out several audits within the past year to support the service improve. The monitoring reports we reviewed showed that the service had made some improvement however, this was not sufficient and consistent across all areas. A professional we spoke with told us, "The service doesn't feel well led at all."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were put at risk of receiving unsafe care and support because their needs were not assessed and care and support was planned to ensure their needs were met.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's privacy and dignity was not always respected.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not always identified, assessed and had appropriate risk management plans in place, medicines were not always managed safely.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Records were not always accurate, complete and presented promptly when required. The systems in place for assessing and monitoring the quality of the service was not always effective. Sufficient staff were not always deployed to ensure people's needs were met.