Creative Support Limited

Creative Support - Duncan Court & Donnybrook Court

Inspection report

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17 November 2016
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 15, 17, 22 and 24 November 2016, and was unannounced on the first day. This was the first inspection since the provider registered this location in June 2016.

Duncan Court and Donnybrook Court is an extra care service which provides care and support to older people and people with dementia over two sites in Tower Hamlets, each of which consists of 40 single flats, with a kitchen, bedroom, living room and shower room. Each building has communal bathrooms on each floor and a communal lounge, dining room, hairdresser and an on-site office. At the time of our inspection the service was supporting 59 people with personal care.

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

People told us that they felt safe, comfortable, respected and well cared for. People received person-centred care through appropriate systems of care planning and review. Staff used tools for exploring people's life stories and found out about people's needs and preferences with regards to their care and lifestyle and staffing hours were provided in a way which was responsive to people's needs.

There were systems in place to ensure the health and safety of people who used the service, which included appropriate risk assessments and regular safety checks of the premises. Managers had appropriate procedures in place and carried out audits which ensured people's care was safe and appropriate and operated an open door policy which meant people could approach them with concerns, questions and complaints. Complaints were taken seriously, and where appropriate the service had taken steps to address people's concerns and learn from them. The service fulfilled its responsibilities to obtain consent to people's care and to check whether people were subject to restrictions on their movement.

Staff received the training and support they needed in order to carry out their roles and were checked prior to employment to ensure they were suitable for their roles. There were staff planners in place to ensure that people received the right care at the right time. Medicines were appropriately recorded and checked to ensure people had received them safely and suspected errors were reported and investigated. Staff received training and observations of their competency to administer medicines.

People benefitted from a varied and interesting programme of activities which demonstrated good links to the community. Most people told us they enjoyed these, but it was not always clear whether people chose not to attend or were missing out. People were supported to attend health appointments and staff looked out for when people may not be well and worked with other professionals to address this. The provider had procedures in place to help protect people from abuse.

We found one breach of regulations regarding notifying the Care Quality Commission of reportable incidents. You can see what action we have told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People who used the service told us they felt safe.

Staff received training in safeguarding adults and understood their responsibilities to report suspected abuse. Where abuse was suspected this was reported to the local authority and appropriately investigated.

The provider had assessed risks to people who used the service and had management plans in place to address these. Staff planners ensured that there were enough staff to support people safely, and there were systems in place to ensure that staff were suitable for their roles.

Medicines were correctly administered by staff who had the appropriate knowledge to do so. Medicines were checked by other staff and audited regularly by managers.

Is the service effective?

Good

The service was effective.

Staff received appropriate training, supervision and appraisals to ensure they had the skills and knowledge to carry out their roles. Consent to care was sought in line with the Mental Capacity Act 2005.

People received support to ensure they received adequate nutrition, and the provider supported people to access health services and maintain good health.

Is the service caring?

Good

The service was caring. People told us staff were kind and treated them with respect.

There was a detailed and varied activities programme including regular and one off events which demonstrated good links with the community. However the provider had not always found out why some people had not engaged with this.

There were methods in place to support people to speak up, including residents meetings and a specialised plan for people with dementia to record their life stories, needs and preferences. People were supported in line with their cultural needs and dignity was promoted by staff.

Is the service responsive?

Good

The service was responsive.

People received support in line with their needs and preferences, supported by staff who knew them well with the aid of detailed care plans which were reviewed regularly. The provider arranged additional care in response to people's needs and were proactive in working with other agencies to address concerns. People were able to ask for help and support.

Complaints were recorded and investigated, and action was taken to ensure the service learnt from people's experiences.

Is the service well-led?

Requires Improvement

The service was not well led in all aspects.

Managers took appropriate action in response to serious incidents; however they did not always report these appropriately to the Care Quality Commission (CQC).

Managers had adequate systems of audit in place to ensure care was delivered safely and appropriately. Managers were approachable by both staff and people who used the service and promoted an open and supportive culture.

Creative Support - Duncan Court & Donnybrook Court

Detailed findings

Background to this inspection

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

This inspection took place on 15 and 24 November 2016, when we visited Duncan Court, and 17 and 22 November, when we visited Donnybrook Court. This inspection was unannounced on the first day; on subsequent days the provider knew we would be returning.

This inspection was carried out by a single inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Prior to carrying out this inspection we reviewed information we held on the service, including notifications of significant events that the provider is required to tell us about. Before the inspection, the provider completed 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.

In carrying out this inspection We spoke with 27 people who used the service and three relatives. We spoke with 13 members of staff which included the area manager, the registered manager, a service delivery manager, three team leaders, six care workers and a member of staff with responsibility for activities. We also spoke with one health and social care professional who was visiting the service.

We reviewed records relating to the care and support of 11 people, such as care plans, risk assessments and logs of care provided, and the records relating to medicines administration for 10 people. We carried out observations in communal areas including planned activities and interactions between people who used the service and staff. We looked at personnel and supervision records for eight staff and looked at records of health and safety checks, rotas and audits.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe. Comments included, "It's definitely a safe place", "I feel totally safe here" and "They are very nice, so I do feel safe." Staff we spoke with told us, "We're alert and watching" and "You get to know people pretty well, so you know if something's wrong."

All staff had had training in safeguarding adults, and the provider carried out yearly safeguarding supervisions to check that staff could recognise signs of abuse and understood their responsibilities to report concerns, and staff we spoke with understood their responsibilities regarding safeguarding. Staff understood that they could whistleblow if their concerns were not acted on, but all staff we spoke with told us that they were confident their managers would take their concerns seriously. One care worker said, "My managers would definitely take it seriously, they're very strict on safeguarding." There were procedures in place to ensure that incidents and accidents were appropriately recorded. It was noted whether medical assistance was required and sought and whether any further actions were required following the incident, and a manager signed off to verify that this had taken place.

Where suspected abuse had taken place, the provider had passed their concerns to the local authority through an agreed protocol, and had worked with the authority to investigate these concerns and take appropriate action. Where staff handled money on people's behalf, we saw that two staff signed for transactions, and two staff also carried out daily checks of the balance at handover. Staff at Duncan Court had recently had a group supervision regarding finances, and the manager at Donnybrook Court had coached staff in the financial recording procedure in order to ensure procedures were standardised across the staff team. Additionally, the service carried out a monthly audit of people's finances. This helped ensure that people were safeguarded against financial abuse.

There were measures in place to ensure that the building was safe. For example, daily checks were carried out by night staff of the security of the building and the safety of communal areas, which were recorded on shift planners, and at handover staff checked that these had been carried out. The manager also carried out monthly health and safety checks, including fire panels and maintenance issues. Where in use, hoists, hospital beds and lifting baths had been professionally serviced, and there were yearly checks of electrical and gas systems. There was a CCTV system which covered the entrances to the building, and the provider maintained a 24 hour on call system, which was displayed in the staff office with clear guidelines for its use. There was a profile of each person prepared for the on call service, with basic information about their care and support needs to use in the event of an emergency.

Both buildings had an up to date fire risk assessment, and there were measures in place to ensure that the fire alarm, call points and fire fighting equipment were tested regularly. Staff had up to date training on fire safety, and each person had a personalised evacuation and egress plan (PEEP) which contained information on how to evacuate the building, including remaining in their flats if appropriate, and information on what support people would need to evacuate safely. Fire drills were carried out twice yearly, and it was recorded whether people who used the service had acted appropriately in line with their PEEPs. There was a list of which flats contained oxygen cylinders displayed by the front door, which meant that fire crews would have

access to this information in an emergency.

There were emergency pull cords in each room in people's flats, which allowed people to speak directly with staff. Three staff in each building carried handsets which allowed them to speak with people. The registered manager told us that they had experienced problems with the system in both buildings, and the landlord had taken measures such as fitting additional beacons to improve reception, and that in the event of a call not being answered this would divert to an external call centre. Staff were required to carry out two hourly checks of the system, this was not always taking place but was being done at least four times a day. We pulled four different cords in each building and staff responded promptly to this. People told us that staff responded quickly when they called for them, with one person telling us, "They always come when I call for them."

Each person who used the service had a missing person's procedure at the front of their file. This contained a photograph of the person, a description and relevant information on their knowledge and understanding about going out. In most cases there were clear timescales for when to report the person missing to police, in some cases there was not a timescale, but the registered manager told us that this was because for those individuals the procedure was to report them missing immediately.

Where people may be at risk, the provider had carried out risk assessments and had plans in place to manage these risks. For example, where people were at risk of falls, there was an assessment of the person's environment, their use of mobility aids and what support they needed to transfer safely. One person was listed as at high risk of falling, and the risk assessment stated that staff needed to ensure that they were in bed and ready to go to sleep before they left, and logs of support showed that this was taking place. Moving and handling assessments had been carried out where staff needed to support the person to make transfers, and this included guidelines for the safe operation of the person's wheelchair. For one person they required the support of two staff to safely make transfers, and logs showed that this was in place for visits where this was required. Where people smoked in their own flats, risk management plans were in place, which included providing fire resistant furniture and bedding, emptying ashtrays regularly and providing metal bins for people. People had been assessed for the risks arising from certain conditions, such as diabetes, dementia and depression. One risk management plan incorrectly stated that a person had dementia, when they had suffered a stroke, however this contained clear information on how to support the person with their cognitive difficulties.

Where people had support with bathing, the provider had assessed the risks associated with this. This included whether the person was able to get in or out with assistance, whether they were able to sit up, wash themselves and summon assistance, and whether they were at risk of scalding by not being able to recognise high temperatures. Risk management plans stated that staff should check the temperature of water before supporting people to bathe, and each person had their own thermometer and a book for recording temperatures. These included clear guidelines for staff on how to check temperatures and what were considered safe temperatures for a bath or shower. In one instance a thermometer had been broken and not replaced for a month, which the provider told us was due to difficulties in ordering thermometers. The provider carried out weekly flushes of vacant outlets as part of a legionella risk assessment.

The provider had staff planners in place to ensure that people received their care, and staffing levels were in line with the requirements of these planners. Some staff told us that they could be short staffed in the event of sickness, but that they usually covered these absences using agency staff and that this was not a regular occurrence. There were also planners in place for the two waking night staff who were in place in each building, which included carrying out night safety checks on people and on the building.

The provider had measures in place to ensure that staff were suitable for their roles. This included obtaining photographic identification, proof of address, proof of their right to work, taking up references and carrying out checks with the Disclosure and Barring Service (DBS). The DBS provides information on people's background, including convictions, in order to help providers make safer recruitment decisions. At the end of this process the person's appointment was signed off by a director. Many staff had transferred from the previous provider, whereby the provider had obtained references from the previous provider and carried out a new check with the DBS. The provider told us it was their policy that DBS checks be repeated every three years, however no staff had been working for the provider for that long.

The provider had measures in place to ensure that people received their medicines safely. Staff had received training in medicines, and managers carried out observations of staff competency to administer medicines and assessments of staff knowledge regarding ordering and receiving medicines and addressing errors. We reviewed the records of 10 people in relation to medicines, and saw that medicines recording charts (MRCs) were correctly prepared and completed by staff. Most medicines were provided in blister packs by the pharmacy, and daily stock checks were being carried out on other medicines. Staff were required to carry out spot checks of people's medicines, including the contents of blister packs and MRCs, and this had been effective in identifying possible errors. People told us that they received their medicines safely. One relative told us that their family member had accidentally taken their medicines, and was admitted to hospital as a result, but added, "Now they lock his/her medication in a tin in his/her room." MRCs were audited for each person on a two monthly basis, including checking whether medicines were correctly recorded, with correct times, clear instructions for staff and information on any allergies the person may have.

Good

Is the service effective?

Our findings

People who used the service felt that staff were adequately trained to meet their needs. One person told us, "Staff know what they are doing." A relative told us, "My [family member's] main carers are excellent."

All staff had undergone a four day induction on joining the service, including staff who had transferred from the previous provider. This included communication, record keeping, dementia awareness, stress and person centred approaches. All staff had undertaken training in key areas such as nutrition and hydration, fire safety, first aid and moving and handling. The provider maintained records of staff training to ensure that staff had received the correct training. Care workers we spoke with were positive about the training they received. Comments included, "They're definitely useful, it's not just a quick training it's quite long" and "training is quite extensive here." Two newer members of staff had said the training was particularly helpful. One care worker told us, "I've had a lot of training since I started, there was so much stuff I didn't know, it was really helpful" and another care worker said, "The training boosted me up and I can deal with situations by myself." All staff we spoke with said they felt confident they could receive additional training if they felt they needed it, with one care worker telling us, "I can always go to them for extra training."

Staff received regular supervisions from their managers, which took place at least quarterly. Supervisions followed a fixed format, which began by reviewing the action plan from the previous supervision, discussing issues relating to particular people, and then reviewed the person's knowledge and skills in key areas such as professional practice, effective communication, safeguarding, health and safety, personal development and reflection. In all cases, managers discussed staff wellbeing and discussed any additional support they required.

Managers also carried out themed supervisions in order to assess and improve their knowledge in other key areas; this included medicines, safeguarding adults and dignity. These supervisions took place yearly. Additionally, staff had a yearly appraisal, which assessed care worker's progress and understanding against the provider's core values, the quality of their work and compiled a personal development plan, including addressing any outstanding training needs.

Staff undertook training in the Mental Capacity Act 2005 (MCA). The Act 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. Staff we spoke with understood their responsibilities to ensure that people were supported to make decisions for themselves.

Most people who used the service had indicated their consent to their care by signing their care plans and risk assessments. In addition, the provider had sought consent to retain keys to their flats and explained why this was needed, and the appropriate consent where people received support with medicines and finances. Where people may not have the capacity to consent to their care, the provider had arranged assessments of capacity to be carried out by the local authority; these were not always on people's files but were provided

on request. In two cases relatives had signed the person's support plans, but there was evidence that the person's capacity had been assessed, and that meetings had taken place with professionals and the person's relatives to demonstrate that they were acting in the person's best interests.

In one case it was recorded that the person had refused to sign their care plan, which had not been further explored, however there was evidence that they had consented to other areas of their care. Logs of support showed that staff asked the person's permission to support them on each visit, and when this was declined staff had left and returned later to offer support.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Records showed that nobody using the service was subject to DoLS. The provider had carried out an assessment of restrictions for each person, which assessed whether they had capacity to make decisions in each area of their care, whether a best interests decision was required, and whether they were subject to restrictions on their movement which may be subject to DoLS.

Where people needed support to eat and prepare meals, this was recorded in their care plans and records showed that this had taken place. There was clear recording of what meals and snacks people had had. One person's plan stated they were to be supported with breakfast every day; records showed that this person had declined support due to feeling unwell, but staff had made one or two additional visits to them later in the morning and had provided breakfast for them when they were ready. When staff were concerned that a person was not eating well and had refused food, this was discussed in reviews involving families and medical support was sought when necessary. One staff member told us of a person who wasn't eating well, and said, "I asked for advice [from another professional] and they encouraged us to offer extra biscuits and fortify their food, we got them back eating."

Many people chose to eat their lunch in the communal lounge. Comments from people included, "There's enough choice, you just order what you like" and "There's a lot of things to choose from so you can't go hungry." One person told us, "Some of the workers are from my country, so if I want [that] food the carers bring it in for me." One staff member said, "I'm from their country, so I could prepare the food they like. When they saw what was there they started to enjoy it."

There was evidence that people were supported to attend appointments and engage with health services. Staff recorded when people had attended appointments and what the outcomes of this were. For a person with diabetes, we saw that there was a healthy eating plan in place, which included supporting the person to be active, and that there were appointments such as retinal checks taking place. For a person with a learning disability, the provider had compiled a hospital passport, which is a document for hospital staff containing information on their support and communication needs to support people with learning disabilities to access hospital services. Another person had been offered support to stop smoking, including the use of smoking cessation aids and electronic cigarettes. Everyone who used the service had a health action plan, which included information about their health needs, contact information for health professionals and the support they required from staff. These had all been reviewed recently, although they did not always include a clear plan about how to support people to maintain their health. During our inspection, we observed two staff discussing in the staff office their concerns about an individual's health, who then contacted the person's doctor to arrange an appointment.

Good

Is the service caring?

Our findings

People we spoke with told us the service was caring. Comments from people included, "They are very caring here", "They treat you as an equal here", and "It's caring here, clean and no noise. It's just a nice environment to live in."

Pictures in the foyers showed pictures of people who used the service and their achievements and activities. There was information displayed about upcoming activities, although some of the information at Duncan Court was out of date. There was an activities co-ordinator who visited both services weekly and volunteers who ran sessions regularly.

Weekly activities included music sessions, an evening group, a fish and chip group, gardening, bingo and church visits. There was a monthly manicure club, quizzes, singing groups, and a programme of other activities which included cake decorating, concerts and operas, a barbecue, tea party, film screening and visits from a local animal group called Furry Tales. At Donnybrook Court there was a weekly "Mums and Babs" group, where parents with young babies participated in activities with people who used the service. There were also day trips taking place regularly, including trips to the seaside, opera, Hampton Court and social events being held at other services run by the provider. We observed a cake decorating group and attended a concert held by a visiting singer. We saw that people were encouraged to participate, for example by being given instruments to join in with the music. There was co-ordination between the services run by the provider, with people from other services attending the concert, and social events on other sites being advertised in the service and people being supported to attend. The provider was working in partnership with a local museum to hold sessions and bring exhibits to the service.

People we spoke with were generally positive about the activities programme. Comments from people included, "I really like the fish and chips and their visits to certain places", "It's good fun, I like joining in", and "I'm not really interested but I do like the company."

The provider maintained records of who had attended the activities. These were usually well attended, but we found that some people generally did not attend activities. A care worker said, "I think they are trying but some people don't want to get involved." One relative said, "My [family member] loves music, I come sometimes and I can hear music, yet she is in her room. I can't be sure if she has said no or if they've just left her out." The provider had a quarterly events forum, where the upcoming programme was discussed and people made suggestions about what they would like to do, but agreed some people were less involved in activities than others. Managers agreed they could do more to involve people in the activities programme. During our inspection, they developed a form they could put under people's doors called 'What would you like to do today?' and showed us some of the responses that they had received.

Residents meeting were taking place monthly, and these were also used to discuss the activities programme, and to discuss areas such as health and safety and security. Support plans also recorded people's views on their care, and that of their relatives, care workers and other professionals, and highlighted areas where there were disagreements.

The provider used a tool called 'It's my life' designed for use with people with dementia. These were completed with sufficient detail to give an overview of people's life stories, likes and dislikes and current lifestyle. There was information on people's preferred hobbies and interests, what people liked or found harder about getting older, what time of day they liked to eat and their preferred food. There was information about people's preferences regarding bathing, including what help they wanted, and whether they preferred baths or showers and their preferred products. There was also information about what people liked to discuss, what helped them to relax and what may upset people. A care worker told us, "I really enjoy listening to people's life stories."

During our visit we observed staff engaged well with people who used the service, and there was a good rapport with people which promoted a pleasant relaxed atmosphere. We observed one person who used the service setting the table for lunch, and the manager told us, "People maintain their skills living here." People frequently came to the office for advice, and were listened to by staff. One person said, "Staff here do listen" and another told us, "They are very nice here." One person said, "I like that I see the same carer all the time, it makes me feel safe and secure here."

Staff gave us examples of how they would support people with their individual needs and culture. Some people were supported to attend church, and a staff member said, "If people are praying we know to come back later." Staff also gave examples of how they had been able to support people to eat food that met their cultural needs. A group of people from the service had attended the London Pride festival, and an attendee had contacted the provider to say, "It was fantastic to see people being supported to be themselves."

The provider carried out yearly "Dignity Challenge" supervisions. This asked staff to reflect on how they demonstrated person-centred care and promoted independence, choice and control and people's right to privacy. People who used the service told us that staff respected their privacy. One person said, "They knock before they come into my flat" and another said, "They always ring my bell and only come in when invited."

Good

Is the service responsive?

Our findings

People told us the service responded well to their needs and preferences. One person said, "They know what time I like my tea and what time I like to get up. They come when it suits me, they are very considerate." Another person said, "[My care worker] helps me then stays and talks with me for a while."

Support plans were detailed and accurately documented people's needs and the support they received. These included people's care needs, mobility and transport needs, the support they needed with medicines and how they preferred to communicate. There was information on people's daily routines, including at night, and the support people needed with shopping, attending appointments and maintaining links with friends and families. This was transferred into a task plan summary, which was used to plan people's care and staff schedules. Support logs showed that people received this care. Staff providing care were required to sign plans and risk assessments to indicate that they had read and understood them.

Staff told us that these were useful documents for delivering person centred care. One staff member said, "They help you interact with people and you can add to them once you get to know someone" and another said, "They help you personalise their care." Staff were able to describe effective ways of working with particular people who were harder to engage with. One staff member told us, "I went into the file and asked my colleagues in order to find out what he/she wants. He'll/She'll say no food, but I know to make it and serve it with pickles and then he'll/she'll eat it." Another staff member said, "We have to find out why they're off and what's wrong."

We saw evidence of how the service responded to people's care needs. Reviews had been carried out regularly, and these discussed the person's progress and strengths, their current care needs and any concerns or unmet needs. The person's responses and satisfaction with their care was recorded. The provider kept records of extra hours which had been provided to people, for example to attend health appointments, and were then claimed from the local authority. The provider had arranged an extra six hours weekly to support a person who was receiving treatment for a serious medical condition. The staff member told us, "[The person] is frightened, but I give plenty of reassurance and say that I'm going with you."

Keyworking sessions were in place, in addition to the support which was agreed with the local authority. Typically these took place once a year, and there was evidence that people had discussed their care with their keyworkers and agreed action plans as a result of these discussions. Although in some cases actions were not clearly agreed, and the form was designed in such a way that sometimes keyworkers recorded information about people's general support needs.

We saw emails which showed how concerns about people were addressed with other professionals. For example, one person was regularly refusing care and another person was at risk from excessive drinking. Staff had contacted social workers and asked for advice or for a professionals meeting to take place. A staff member told us, "If we're concerned about something things do move quite quickly." We spoke with a health and social care professional who was visiting the service who told us, "I find it a person-centred approach. They are very proactive."

There was a complaints policy displayed in communal areas. People we spoke with felt the need to complain was rare, and could not remember having to make complaints, but everyone we spoke with knew how to raise a complaint. Staff told us, "I always say if you want a complaints' form you've got a right to be heard and to complain" and "People feel they can make a complaint, it's a very open door policy." Throughout our visit, we saw people who used the service approaching the front office with questions and concerns, which were promptly addressed by care workers and managers. One relative told us that items had gone missing from their family member's flat, and that managers had addressed this, and had agreed to replace the items if they had not been found by the end of the week.

The provider maintained a system for recording complaints. This showed that complaints were acknowledged and investigated, and recorded learning and actions taken as a result of the complaint. For example, one person complained that they had been unable to access the building, and that staff had not acknowledged them on arrival. The provider had apologised, and had spoken to the staff who were on duty that day. In addition, a memo reminding staff of their responsibilities towards visitors had been placed in the staff office, and at the time of our visit staff were signing to indicate they had read and understood this.

Requires Improvement

Is the service well-led?

Our findings

Where incidents had occurred, managers had sought the appropriate advice and guidance and informed the local authorities of allegations of abuse. In most cases the provider had fulfilled their responsibilities to notify the Care Quality Commission of serious incidents. However, three notifiable incidents were not reported to CQC; this concerned two occasions the police attended the premises with regards to a missing person, and one occasion where an allegation of abuse was made. Incident reporting forms required staff to specify whether the incident was reported to CQC, but did not specify to staff exactly what types of incident were notifiable.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Systems of audit were in place in order to detect errors and ensure high quality care. For example, monthly audits of care notes were carried out by managers to check whether logs of care were correctly completed and whether they demonstrated that the right care had been provided. Managers also checked that food and drink had been provided appropriately and that any concerns noted by staff had been addressed. In addition, managers had introduced a requirement for all staff to carry out daily spot checks on people's care, although this was focussed on medicines it also required staff to check people's welfare, the cleanliness of their flats and the condition of their food and fridge. In practice, this was carried out weekly for each person. Managers also maintained an index of audits so that they could be sure that people had had essential checks carried out.

Managers were visible in the service and were approachable. People who used the service and their families told us they knew who the managers were and that they could approach them with questions and concerns. Both service managers based themselves in the downstairs office where staff and people who used the service could come and speak with them, which we saw happening throughout our visit. We saw examples of managers demonstrating good relationships with people who used the service, for example by going into the lounge, talking to people and checking on their wellbeing. One service manager had recently started work, and we saw that this manager was already well known amongst people who used the service. One staff member told us, "She's really gone out of her way to get to know the tenants and make sure people feel she's approachable." Managers in one building had recently revised the recording process for financial transactions, and we saw a manager providing coaching and instructions for staff in order to ensure they understood their responsibilities.

Supervision records showed evidence of staff receiving support from managers for personal issues such as sickness and bereavement. All staff we spoke with were positive about the support they received. Comments from care workers included, "I find this company supportive, they have supported us a lot", "They look out for us" and "They're very supportive, I wouldn't have made it this far."

Staff told us that there was good morale in the service and people worked well together. Newer members of staff told us of the support they had received from managers and colleagues to settle into the service. A care worker told us, "The teamwork is great", and another said, "I'm very happy with my colleagues, everyone's

good and supportive here." Team meetings took place monthly, and were used to discuss approaches and particular concerns about individual people who used the service. Managers used team meetings as an opportunity to clarify their expectations on staff in areas such as recording, reporting of errors, carrying out spot checks and to discuss rotas and shift changes.

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 registered person did not notify the Commission without delay about incidents of or allegations of abuse in relation to a service user or of incidents reported to or investigated by the police 18(1)(2)(e)(f)