

Thurrock Borough Council

Extra Care Service

Inspection report

Southend Road
Grays
Essex
RM17 5RS

Tel: 01375652856
Website: www.thurrock.gov.uk

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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 announced inspection took place on the 11 and 13 October 2016.

Extra Care Service provides personal care and support to people living in their own homes, within a housing complex benefiting from communal areas. At the time of our inspection there were 45 people using the service.

The service is required to and did have 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. However, the registered manager had been absent from the service for several months in which time the deputy manager and service manager had been overseeing this role. A manager had been newly appointed in October 2016 for the interim period.

There had been a lack of leadership within the service which the provider addressed by appointing an interim manager. The service needed to develop more robust quality assurance systems. Although some processes were in place, effective monitoring and auditing systems at service level were required to drive improvements and ensure consistent, high quality, safe and effective care.

The management of medicines was not always safe and improvements were required to the service's practices with regard to the recording, monitoring and auditing of medications administered.

Care records in respect of people's medication, health and specific end of life care did not adequately reflect people's needs. Care plans were not audited regularly to ensure they contained accurate information to support people effectively.

Care workers were not supported regularly through formal supervisions or appraisals. Competency checks were also not carried out to ensure people were receiving care and support from adequately skilled and competent care workers. Required training and refresher courses were not monitored effectively and in some instances it could not be verified if care workers had completed certain courses. Concerns were responded to immediately by the service.

People's nutritional needs were supported adequately and care workers were mindful of people's wellbeing and helped people to get involved in activities to avoid social isolation. People and their relatives knew how to make a complaint; complaints had been resolved and documented appropriately. However analysis of complaints needed to be more robust to drive improvements.

The service responded to people's concerns immediately and appropriately about lack of dignity and respect for privacy from care workers towards people. The majority of comments reported care workers

were respectful and caring towards people. Care was predominantly provided in a way that intended to promote people's independence and wellbeing.

People felt safe and care workers voiced adequate understanding of how to keep people safe and avoid harm. Management and the provider had taken steps to ensure that sufficient members of staff would meet people's individual needs consistently and within reasonable time frames. A robust recruitment process was in place and staff were employed upon completion of appropriate checks.

Staff supported people to ensure they received access to healthcare services when required. Management and staff understood their responsibilities and the framework of the Mental Capacity Act 2005 (MCA) despite management being unable to demonstrate adequate training. Care workers supported people to maintain their independence and make their own choices.

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 consistently safe.

People's medication administration records were not consistently recorded or audited adequately to ensure safe administration of medicines.

Plans had been implemented to ensure staffing levels improved.

Risks were appropriately managed or mitigated so as to ensure people's safety and wellbeing.

Appropriate checks were carried out making the recruitment process effective in recruiting skilled staff.

Is the service effective?

Requires Improvement ●

The service was not consistently effective.

Although the induction process was robust, regular supervisions and appraisals had not been consistent.

Although care workers had good knowledge, a lack of monitoring resulted in management being unable to verify if care workers had received some required training or refresher courses. Competency spot checks were also not carried out to ensure people received effective care from competent staff.

People were supported with their nutritional needs effectively.

Is the service caring?

Good ●

The service was caring.

The service responded to reports of lack of respect for people's privacy and dignity immediately and appropriately.

Care workers treated people kindly and positive relationships had been formed.

People were supported to use advocacy services to ensure their voice was heard.

Is the service responsive?

The service was not consistently responsive.

There were no end of life care plans in place where required to ensure people's end of life wishes were met.

Care plans were person centred although not audited by the service to ensure accurate information was provided to care workers.

Individual complaints were responded to appropriately but analysis of complaints needed to be more robust to drive improvements.

Requires Improvement 

Is the service well-led?

The service was not consistently well-led.

The service needed to develop more robust quality assurance systems to help ensure people receive high quality, safe care.

There had been a lack of leadership within the service which had impacted negatively upon governance. The provider had addressed these concerns of leadership and appointed an interim manager.

Staff felt supported by each other and had created an open and person centred culture despite the lack of leadership.

Requires Improvement 

Extra Care Service

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.

We inspected Extra Care Service on the 11 and 13 October 2016 and the inspection was announced. The provider was given 48 hours' notice because the service provides a domiciliary care service and we need to ensure that someone would be available. The inspection was carried out by two inspectors on 11 October and one inspector on 13 October.

Before the inspection we reviewed previous reports and notifications that are held on the CQC database. Notifications are important events that the service has to let the CQC know about by law.

We spoke with eleven people, one relative, three members of staff, two care co-ordinators, the deputy manager, the service manager, newly appointed interim manager and the provider. We observed interactions between staff and people. We looked at management records including daily rotas, four people's individual care records, risk assessments and daily records of care and support given. We looked at three staff recruitment and support files, training records and quality assurance information.

Is the service safe?

Our findings

Safe management of medicines was inconsistent. Several people we spoke with were happy and supported to self-medicate. One person told us how they used to be supported to have their medications administered to them although now they self-medicate as their health had improved. People's care records contained medication risk assessments which identified people's basic needs regarding their medicines. However, information within care records did not consistently provide enough information to ensure that staff would know how to manage medicines safely. One person was prescribed Warfarin which was important to take exactly as directed. The management of this medication was shared between care workers and family. Although this information was indicated in the person's home, it was not recorded in the person's care plan, as required in the service's own medication policy. We discussed this with the care co-ordinator who took immediate steps to update the care plan appropriately.

Information regarding another person's medication was documented on staff rotas communicating that eye drops were to be given in the person's right eye on specific visits. They told us, "Yes, I am happy with how they give me my eye drops." However within the person's care plan it simply stated that they took 'eye drops' for an eye condition. No further information was provided within the care plan. Additionally, it was not clear from the person's daily Medication Administration Record (MAR), stored in their home, whether they had received the correct eye drops consistently at the right time.

MAR charts of the people being administered medications had not been monitored or audited regularly. The care co-ordinator and deputy manager confirmed that MAR charts were not monitored or audited to ensure people received their medications as prescribed. The MAR charts that we saw in people's homes were not always complete with the person's name and they did not state any allergies people may have. Some of the entries from care workers were illegible and detailed the description and tablet colour rather than the medication and dose. Blister pack contents were not attached as part of the homes permanent records so it was not possible to identify what medications people had been taking weeks or months prior to the current blister pack being administered.

One care worker told us that they had regular updates regarding medications and stressed the importance that medications should be administered properly. However, the service was unable to verify when seven care workers had last received training in medication administration or demonstrate that competency checks had been carried out to ensure people were receiving their medications safely. This demonstrated that medication needs were not being managed consistently or safely.

These failings are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care workers were knowledgeable of the signs of potential abuse and they knew how to protect people from harm and keep people safe. The service also had a policy for staff to follow on safeguarding and whistle blowing and staff knew they could contact outside authorities such as the Care Quality Commission (CQC) and local authorities. One care worker told us, "I know I could speak to a care co-ordinator if I had a concern

and if concerns carried on I would speak to local authorities." The service manager, deputy manager and care co-ordinators had a good understanding of their responsibility to safeguard people and knew how to make referrals to the local safeguarding authority to investigate if they needed to raise concerns. However care workers knowledge was not being monitored effectively. The training matrix provided to us could not demonstrate when eight care workers had last received training in how to safeguard people from abuse. The deputy manager took immediate steps and scheduled care workers to complete safeguarding training before mid-December 2016.

Risks to individuals were managed safely and people reported that they felt safe during personal care. Care records we looked at indicated people's specific needs and risks, for example, individual moving and handling assessments. One person's care records we looked at told us they required a hoist and contained information to specify the type and size of handling equipment and methodology for each specific activity. One person told us, "I didn't like the hoist at first, but they [care workers] are very good at getting me up. I always feel safe because there's always two people to support me." Care workers had received their moving and handling training and had been scheduled to undertake refresher courses to keep people safe.

People were cared for in safe environments. Risks of the environment were assessed in people's own homes and there was an Emergency Evacuation Plan in place should the premises need to be evacuated and emergency contingency plans implemented. Fire alarms were also tested once a week.

The service had taken steps to make sure that there were sufficient numbers of staff to keep people safe and meet their needs. Care workers told us consistently that although their days were busy they felt they could manage people's needs effectively. One care worker told us, "It's swings and roundabouts; some days are busy and other days we have more time." Care co-ordinators told us that managing staffing levels had been difficult particularly at weekends when they were understaffed. Agency, bank and existing members of staff were used to cover shortfalls. Care co-ordinators had raised concerns with the service manager who had performed a review of resources and the provider had agreed to recruit extra care workers to meet the demand of people's needs. A recruitment drive had been successful and new rotas were being devised by the care co-ordinators to ensure people received their calls as consistently as possible.

People consistently told us that care workers were not always on time. However the majority of people reported to us they understood the pressures of the care workers role and others told us they liked the flexibility of care workers arriving at different times. One person told us, "They come at all different times of the day but that doesn't bother me, I like them coming in for a chat. When they used to help me with my medications they were more on time." Another person told us, "They are late sometimes, but not all the time." We observed that due to the nature of the premises, there was a lot of activity in communal areas. Care workers visited people's homes not only for scheduled visits but when people needed ad-hoc support, for example, when people required assistance moving from their home into communal areas.

Many people living within the premises had received support when it had been an enhanced sheltered housing service, staffed 24 hours a day. The service was now a domiciliary care service supporting people's independence between 7am and half past midnight with an on call, out of hours Emergency Duty Team. Therefore some people's understanding of how the service had evolved had become blurred and may have expected more than what would ordinarily be expected of a domiciliary care service. The provider confirmed to us that a new computerised system had been planned, to be implemented imminently which would enable the service to monitor people's call times and activity of care workers more effectively.

An effective system was in place for safe staff recruitment. This recruitment procedure included processing applications and conducting employment interviews. Staff files we looked at contained adequate

recruitment documentation. Many of the care workers were long standing employees and relevant checks were carried out before a new member of staff started working at the service. These included obtaining references, ensuring that the applicant provided proof of their identity and undertaking a criminal record check with the Disclosure and Barring Service (DBS). Staff we spoke with told us they had interviews and supplied all the relevant documents before starting work at the service.

Is the service effective?

Our findings

Regular training, formal supervisions and appraisals were not consistent. Although care workers told us they received formal and informal supervisions, the matrix we were provided with indicated that formal supervisions were not carried out in accordance with the service agreement of every other month in addition to staff meetings. Supervision notes we saw within care workers support files were comprehensive and covered topics such as, performance, learning and development, support and mediation. However, the frequency of supervisions was inconsistent; seven care workers had received only one supervision since December 2015. Appraisals had also not been completed for 18 months in the three care workers' support files we viewed. Meeting minutes we viewed from May 2016 also indicated that supervisions were not up to date and needed to be addressed immediately. The service manager, care co-ordinators and deputy manager advised us that supervisions and appraisals had not been carried out regularly by the care co-ordinators due to the absence of the registered manager and reduction in the number of care co-ordinators since the service had evolved. Without regular supervision and review of staff practice, the provider could not be assured that staff were being given the opportunity to discuss their performance, development and support needs to allow them to fulfil their role effectively.

Care workers reported that they felt they had received enough training to fulfil their role. One care worker told us, "There is so much ongoing training; you can always ask if you need training. People are getting more dependent so it's important to do your training." The service manager supplied us with an updated training matrix which reflected required and refresher training completed and scheduled for care workers. However, the training matrix was incomplete and it could not be verified by management when care workers had completed their required training or when refresher courses were due, such as; health and safety, first aid, infection control, safeguarding, dementia and mental capacity act. The service manager did assure us that care workers were in the process of being scheduled onto training courses with Thurrock Council's Learning team and other providers to ensure that these concerns were addressed immediately.

Competency spot checks were not consistently carried out to ensure people received effective care. When we requested information to demonstrate how the service assured themselves of the competency of their care workers the managers were unable to provide any evidence of competency spot checks having been carried out. Therefore we could not be assured that care workers had received the necessary training and support they needed to carry out their roles and responsibilities so as to meet people's needs effectively.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although no new care workers had completed the recruitment process over the last 12 months the service manager confirmed that suitable new staff would be enrolled on the Care Certificate. This is an industry recognised set of minimum standards to be included as part of the induction training of new care staff. The service manager also informed us that all new care workers being recruited would undertake a corporate induction as well as an induction to the service. New care workers would also be given the opportunity to 'shadow' and work alongside more experienced members of staff to understand people's needs. We saw

agency staff carrying out their inductions to the service and arranging further days to 'shadow' experienced staff.

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 had in place a lasting power of attorney, where appropriate. People were encouraged to make their own decisions even if these were unwise. For example one person chose not to go to bed before midnight even though they knew there was a risk of falling getting to bed without support. A care co-ordinator told us that plans had been put in place to avoid risk as much as possible, although they had to respect the person's wishes.

Care workers had a good understanding of the Mental Capacity Act. One care worker told us, "We have to be aware that they [people] have the capacity to do things themselves. We must not deprive people of their liberty. This can change and we may have to make choices for people but we must give people the freedom to make choices themselves." Staff understood how to help people make choices on a day to day basis and how to support them in making decisions. We saw good practices in providing people with choice. For example we saw in people's daily records that care workers discussed with the people about what food they would like prepared for them, transfers between furniture and whether they would like to participate in daily activities. People had also signed their care plans to document that they had been asked and consented to the daily care and support provided.

People were supported with their nutritional needs appropriately. The service provided a café on Tuesdays and Thursdays where people chose to enjoy eating a fresh home cooked lunch together. One person told us, "The food is delicious it tastes as good as it smells." Another person said, "I am a diabetic so it's nice to come down and have a good meal twice a week." Fish and chips were also delivered to the service on a Friday for those who wanted to participate. Care workers helped people participate in social meal times and/or to prepare their meals in their homes, where required. One care worker told us, "People's nutrition is very important, we have to make sure they are eating well. If not we need to request help, I would speak to my manager." Another person told us, "They [care workers] always make sure I have drinks and enough food. They [care workers] will put my meals in the microwave for me if my daughter isn't here."

People had access to healthcare professionals. The service manager told us, all appointments regarding people's health were recorded within the day communication book. We saw people's appointments recorded within this documentation. We also saw a care worker and care co-ordinator who discussed the need to arrange a GP appointment as they felt one person was unwell that day. Many people told us they were independent and/or had good support from family although people consistently told us that they felt care co-ordinators would assist them with arranging health care appointments if needed. One person told us, "They [care workers] always make sure the nurse has come and dressed my knee every morning." A district nurse reported to us, "They [Extra Care Service] always contact us and raise any concerns they have for anybody, I've never had any problems or cause for concern. The staff follow any instructions we provide and I think the staff are competent and work well together."

Although we had discussions with care co-ordinators and people about how the service supported people to maintain good health there was inconsistency regarding the documenting of actions taken by the service in response to referrals made. Care co-ordinators, the service manager and deputy manager told us they understood the importance of documenting and monitoring the health of people. The service manager advised that improvements would be made accordingly to ensure that people's care records would clearly

document any correspondence with family or referrals to and follow ups from health care professionals.

Is the service caring?

Our findings

People's comments about privacy and dignity were variable. Three people we spoke with felt their privacy and dignity was not respected adequately by care workers. One person told us, "Someone came in my home the other day and took something of my table without saying a word to me." Another person told us, "They don't always knock they just let themselves in. I think respect for privacy is lacking. I would like just 10-15 seconds to be able to get up and answer my own door." Although these two people had concerns regarding their privacy they had not reported these concerns to the management. Another person told us how they hadn't liked the attitude of a care worker who had supported them which was rectified immediately when they had told management.

We advised the deputy manager and care co-ordinator of these concerns and we were told that these matters would be addressed sensitively and that all care workers had been scheduled to complete person centred care training by the end of November 2016. This action had been driven in response to a weekly provider action plan which had highlighted a need for the service to ensure provision of person centred care. Eight of the 11 people we spoke with did not report a lack of respect for their dignity and privacy and were content with the care and support being received. One person told us, "I am quite happy here. I have a nice home that the girls [care workers] respect. I'm very grateful to them." We also saw care workers treating people respectfully. For example, we saw one care worker interacting well with a person in their wheelchair and asking them where they would like to be taken to.

People were generally complimentary of the support and care that staff provided to them. One relative told us, "The staff are very friendly. They know [person's name] and remember them well even though they're only here again for respite." Care workers and care co-ordinators we spoke with were able to speak of people in detail. We were assured that staff we spoke with knew the people they cared for, including their preferences and personal histories.

Positive caring relationships had been developed. We saw friendly and comfortable exchanges of conversation between people and care workers. We saw one person deliver some home-made food to the care co-ordinators' office to say thank you for all the support provided to them. The person told us, "I'm 150% happy with them [Extra Care Service]. They go out of their way for you." Another person told us, "I'm really happy with them [care workers], a few good ones have left but they are all really friendly."

People were supported to express their views and be actively involved in making decisions about their support. One person told us, "I don't like to go to bed early so now they come around midnight, that's much better, I'm happy with that." Another person explained how their supported hours had been assessed and reduced but care workers still ensured they had everything they need. The person told us, "I don't have a lunch visit anymore but they [care workers] ask me if I want a sandwich made in the morning so I can eat it at lunch." This demonstrated that care workers showed concern for people in a meaningful way.

The care workers were aware of advocacy services and when people might require these services to make their voice heard. One person was supported to obtain an advocate and told us, "I have an advocate that

will take me for appointments about my health."

Is the service responsive?

Our findings

Appropriate arrangements were in place to assess the needs of people prior to admission. People and those acting on their behalf had been involved in the development and review of their care plan.

The care co-ordinator told us that the format of care plans were still in the process of being updated for the purpose of being uniform across sister services. This would provide consistency and familiarity of documentation for care workers who worked between services. This had occurred in response to staff feedback.

We saw some care plans that had been updated using the new format when a change in need had been identified. We also saw one person discussing their care plan with the care co-ordinator. The care co-ordinator then updated the care plan and gained a signature to confirm that the person consented to receive the care and support provided. People regularly told us the care workers discussed their care with them and we saw care plans in every person's home we visited. One person told us, "Yes I have my care plan, if they or I mention anything new to my care it's updated and it also shows the daily routine the carers have to follow."

Some people's care plans contained sufficient detail to give care workers the information they needed to provide personalised care and support. For example one person's care records clearly stated '[Persons name] must have her pendant on at all times.' The person told us, "They make sure they put my pendant on my wrist in case I fall I can get help." We saw that the person was wearing their pendant.

However, people's needs were not consistently recorded in the same way for ease of reference. Some care plans were not as fully reflective or accurate of people's care needs as others. In addition to care plans, daily work rotas were used by care workers which contained person centred information to assist them when providing care that was responsive to people's individual needs. Although the daily work rota was a useful tool for care workers to be reminded of each individual's most significant needs, confusion arose when information within the daily work rota was not reflected in the person's care records and vice versa.

For example we saw one person's specific need detailed on a work rota, however when we asked the person if care workers met this need they weren't sure if their need was being met or not. There was no other documentation that stated this need was required. The care co-ordinator confirmed this need was no longer current and the person centred information on the daily work rotas had not been updated. This meant that care workers were referring to people's needs on documents that had not been kept up to date. The care co-ordinator investigated the situation appropriately and updated the work rotas accordingly.

The provider's quality monitoring report from May 2016 had identified the need for the service to regularly review the effectiveness of care plans and ensure that they are kept up to date to support people's changing needs. In addition the service manager provided us with an updated weekly action plan from 3 October 2016 which identified the need for the service to complete accurate care plans for each person receiving support. These identified issues had not been robustly rectified or monitored as they were still present during our

inspection. The service manager and interim manager assured us that systems would be put in place to ensure people's needs would be regularly assessed, documented and reviewed.

Although people's original Do Not Attempt Resuscitation (DNAR) documentation were stored within their homes and a copy in the office file, end of life care plans were not evident within people's care records. This meant that people had not been supported by the service to communicate their preferences and choices for their end of life care. We discussed these concerns with the provider, care co-ordinator, service manager and interim manager who all agreed that people's care records would be updated to include an end of life care plan detailing their preferred priorities for care.

Friendships had formed between people using the service. Although Extra Care Service is a domiciliary care service the nature of the building and the attitude of the care workers supported people to build and maintain friendships with each other. In turn social isolation was avoided. We saw care workers help people meet each other in the lounge throughout the day. They took part in activities such as Bingo, watching television together, chatting, keep fit and meal times. The environment and atmosphere was friendly and people told us how important this inclusion was to them. One person told us, "Everyone [people and care workers] have helped me so much since my husband died." Another person told us, "I felt so lost when I came but everyone is friendly here."

The service responded to people's needs and independence was encouraged. One person's care records prompt care workers daily to, 'Encourage [person's name] to complete tasks herself.' Another person told us how their health had improved significantly. The care co-ordinators had arranged for their support time to be reviewed so as to promote the person's independence. We also heard care workers feeding back to care co-ordinators that one person's care was taking longer than the initial assessment time. The care co-ordinators explained that it was necessary to reassess people's needs constantly and liaise with authorities regularly to ensure people received the correct amount of time to best support their needs.

The service listened and responded to people's experiences. People told us how the care workers responded to their needs to ensure their health and wellbeing. One person told us, "I can fall over easily but if I do fall they [care workers] come really quickly." We saw plans had been put in place and discussions had been had with family members to reduce risks for this person. Another person told us how sometimes you can feel lonely but, "They ask me if I want to go down and join others for fish and chips or Bingo in the lounge." Yearly quality monitoring questionnaires were distributed to gain people's views of the service. Although questionnaires were only distributed to people and not others for example, health care professionals or stakeholders, it was evident from the feedback that any concerns identified were highlighted and addressed immediately such as, respect and staffing levels.

The service had policies and procedures in place for receiving and dealing with complaints and concerns received. Complaints were also screened by the provider's safeguarding team to ensure people were protected. People and appropriate persons told us that if they had any worries or concerns they would discuss these with the care co-ordinators on duty. One person told us, "I have made a complaint before and was happy with how it was handled." The service manager told us, "We encourage people to complain so we can make improvements, they have procedures in their own homes which details how they can make a complaint." We saw evidence of complaints that had been investigated appropriately and subsequent outcomes documented. Although individual complaints were dealt with accordingly and the weekly provider action plan identified that all complaints must be collected and responded to in an appropriate manner, there was no evidence of complaints analysis to identify potential themes of where to drive improvement within the service. The service manager and interim manager assured us this would be addressed.

Is the service well-led?

Our findings

The service did not have robust records and data management systems. The lack of leadership had impacted negatively upon quality monitoring at service level. Records relating to staff employed and people using the service were not properly maintained. Care plans were not audited regularly to ensure they contained accurate information. End of life care plans had not been discussed or created with people. General and medication competency assessments had not been completed to ensure that staff who administered medication to people using the service were competent to undertake this task safely and provide care to an appropriate standard. Medication audits were not undertaken to ensure people were administered medications safely and in accordance to their needs. Suitable systems were not in place to ensure that staff were appropriately supported, supervised and trained. Care workers had not received regular appraisals. Late and missed calls were not monitored effectively. Incidents and accidents had not been documented effectively with actions taken and learning outcomes since October 2015. The service was unable to evidence how they monitored or analysed incidents and accidents to identify areas for improvement.

The service manager provided us with documentation that evidenced how they gained people's views of the service. Questionnaires were distributed to people who used the service and those acting on their behalf. A total of 17 questionnaires in 2016 had been responded to and individual concerns were addressed directly to improve the quality of individual experience. However questionnaire responses were not distributed as widely as they could have been or used to create action plans and drive service improvements.

The service manager showed us the provider's comprehensive monitoring report completed in May 2016 which was also used to monitor the quality of the service. This report identified issues within the service such as; supporting staff and maintaining records of supervisions and training, management of medicines and management of staffing levels. Although quality assurance tools were in place and action plans had been created by the provider to respond to concerns, we found that the identified issues from May 2016 hadn't been resolved. The service manager had been overseeing the service and identifying areas of improvement, although there had been an absence of leadership within the service to resolve identified issues. This lack of leadership and poor responses to concerns identified, including a lack of robust quality monitoring had resulted in poor governance, which increased risks to people's safety and wellbeing.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service promoted an open and person centred culture which had been created within the teams of care workers. We observed people and care workers interacting positively discussing support and care needs with discretion. Despite a lack of leadership care workers we spoke with remained upbeat. A care worker told us, "Care co-ordinators and the deputy manager are fantastic I could not fault any of them with the support I have received." Another care worker told us, "The care co-ordinators are very good, very considerate and confident. We all work together well and I look forward to coming in. Everyone is happy working here." The care co-ordinators reported to us the pressures that they had faced to ensure people

received adequate care and that staff felt supported. They expressed these objectives had been difficult to achieve without appropriate leadership within the service. We saw evidence from staff meetings in May 2016 that there had been reports of poor morale and tension amongst care workers. Management had promoted respect and understanding of others strengths and weaknesses. However there had been no follow up regarding poor staff morale in the minutes of meeting held in June 2016. No more meetings had been held until October 2016. Nevertheless it appeared that the care co-ordinators and deputy manager had enabled and encouraged open communication amongst care workers and people through a period of change. The interim manager reported to us their eagerness to take on the responsibility of delivering high quality care and create a team who have a shared understanding of how to achieve the key challenges ahead.

The provider had made plans to improve good management and quality. For instance, a recruitment drive to address staffing levels and new software to help monitor visits to people effectively. Nevertheless these plans had not been completed at the time of inspection. The provider also informed us that the interim manager, who had been appointed, would support Extra Care Service to fully meet the Commission's standards and ensure robust governance would be put in place. At the time of inspection the interim manager had only been appointed for a matter of days and was gaining an understanding of the daily operations. However, they did provide assurances with regard to a presence of leadership by informing us, "I have a great deal of experience in achieving 'Good' and 'Outstanding' rated services. I understand what auditing systems need to be in place to assure ourselves that quality is being achieved. You cannot rely on feedback from care workers and people alone, audits need to be done to make sure people's needs are being met." We were reassured that plans were being put in place by the provider to improve management and leadership within the service.

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 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 - Safe care and treatment was not being provided because the service was not ensuring staff were competent in the management and administration of medicines. Effective auditing systems were not in place to ensure the service was mitigating against risks.
Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 - Poor governance resulted in lack of effective systems and processes to ensure the provider was mitigating against risks.
Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 - The inadequate monitoring and provision of sufficient staff training and supervision placed people's health and wellbeing at risk.