

Methodist Homes The Hawthorns

Inspection report

The Hawthorns
Naylor Crescent, Netherpool Road
Ellesmere Port
Merseyside
CH66 1TW

Date of inspection visit:
25 July 2016
26 July 2016
02 August 2016

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19 August 2016

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

An announced inspection took place on the 25, 26 July and 2 August 2016.

We gave short notice as this was a personal care service and we wanted to be sure that someone from the service could meet with us. We also asked the registered manager to seek, in advance, consent from people who used the service to speak with us.

The service was last inspected on 21 August 2014 and at the time it met the requirements of the outcomes inspected.

The Hawthorn's Care Housing is adapted single household accommodation that is occupied under a tenancy agreement which gives exclusive possession of a home with its own front door to the people that live there. The accommodation also has a communal lounge area and dining room for the use of the tenants. The property is designed to enable and facilitate the delivery of personal care and support to people, now or when they need it in the future. A personal care service can be provided by the staff based at the site and staff can deliver care in an emergency. People can choose to commission care from other agencies in the area.

There was registered manager who had been registered at the service since February 2016. A registered manager is a person who has registered with the CQC 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 and associated Regulations about how the service is run.

We found that the registered provider was not meeting some legal requirements and we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

People said they received the right level of support from staff and described them as "reliable" "caring" and "marvellous". This inspection found that people did not always have their wishes respected by staff in matters relating to their wishes and preferences.

Staff knew people well and showed an interest in their lives. People were supported to meet their physical, emotional, spiritual and social needs. However, records kept by the service did not always clearly identify the risks, needs, preferences and wishes associated with each individual. This meant that staff less familiar with a person may not deliver the support required.

Choices were offered by staff and the consent of people sought before providing support. Some people lacked the mental capacity to make some decisions. Staff were aware of what was required to ensure that their rights were protected and made decisions in their best interest. We made a recommendation that the registered provider ensure this is better demonstrated within records to comply fully with the Mental Capacity Act.

People were provided with information about the service and their opinion was sought as to how it could be further improved. People felt able to raise concerns as they felt the registered manager and the staff were approachable.

Living at The Hawthorn's combined with the support received made people feel safe and secure. There were safeguarding policies and procedures in place which staff were knowledgeable about. We saw that staff were confident to highlight concerns and swift action was taken by the registered manager ensure that people were safe and cared for.

Safe recruitment procedures were in place and were followed. Staff had the relevant pre- employment checks including those from the Disclosure and Barring Service. Staff had been given regular supervision, appraisal and support in their role. Their training needs had been identified in order to improve their knowledge and competence. This meant that people could be assured that staff were employed with the right character and skills to provide their support.

There were systems in place to record and monitor accidents, incidents, staff practice and any health and safety concerns. Action was taken where improvements could be identified. Quality assurance systems were in place to monitor the effectiveness of the service. We found that this was not robust in all areas. We made a recommendation that the audit system for records should be improved.

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 completely safe.

Records relating to the risks associated with health conditions were not always documented and people may not receive the oversight that was required.

Systems were in place to promote the safe administration of medicines and people received these as prescribed. The registered manager had highlighted any short falls in practice to ensure improvements were made.

People said that they were kept safe and staff knew how to recognise and report any safeguarding concerns. People were supported by staff that had been deemed of suitable character and skills to work within the social care sector.

Requires Improvement ●

Is the service effective?

The service was effective.

Staff were aware of the Mental Capacity Act 2005 and the implications of this upon their day to day work. Improvements were needed to ensure that records reflected this practice.

Staff received a good induction, regular supervision, appraisal and training. This helped to ensure that they were competent and confident in their roles.

Staff ensured people were given the support required to seek support with health needs. Staff ensured that people maintained a good diet and fluid intake.

Good ●

Is the service caring?

The service was not always caring.

We found that people's preferences in regards to the gender of their carer were not always recorded or met.

People were complimentary about the support they received and said that the staff were very kind and caring towards them.

Requires Improvement ●

People were supported by a Chaplain who helped meet their spiritual needs.

People told us that the staff group was consistent and they liked the continuity this gave them.

Is the service responsive?

The service was not fully responsive.

Staff knew people's needs and how to meet them. However, care plans did not always contain the information required to help staff provide individualised care.

People received support from staff who knew them well. Staff provided a flexible service and were available to respond in an emergency.

There was a complaints procedure in place but people informed us that they rarely had cause to grumble.

Requires Improvement ●

Is the service well-led?

The service was well-led.

There was a registered manager that people and staff thought was professional, fair and understanding.

A quality assurance system in place for oversight of the service from the registered manager and the registered provider but this was not always effective.

Staff and people who used the service were kept up to date with things that affected them. Policies and procedures were regularly updated.

Requires Improvement ●

The Hawthorns

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 25 and 26 July and 2 August 2016 and was announced.

The registered provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available.

The inspection was carried out by one adult social care inspector.

Before the inspection we reviewed that information that we held on the service from notifications, questionnaires, safeguarding and complaints.

During the inspection we spoke to ten people who received a personal care service and one visitor.

We interviewed five staff in addition to speaking with the registered manager and area manager. We also listened and observed staff interaction with people and other professionals.

We looked at the care plan records for thirteen people who used the service. This included care plans, medication administration records and daily notes.

We reviewed a variety of records in regards to the management of the service. This included five staff recruitment files, supervision and training records, audits and health and safety information.

We contacted the local authority: safeguarding and commissioning who did not have any concerns about the service.

Is the service safe?

Our findings

People who received support told us that the service made them feel safe. Comments included "I have the best of both worlds: my own from door but staff on hand to make me feel safe" and "It's good to have staff to make you feel reassured when you feel anxious".

Risk assessments were undertaken in terms of the environment to ensure that it was safe for staff and tenants. However, care plans did not contain robust risk assessments or management plans to support staff where an aspect of a person's physical or mental health gave cause for concern. There was a lack of specific information in regards to the monitoring or recognition of health conditions. For example, records indicated that staff supported people with diabetes. Staff were able to tell us what they did to support and monitor but there was no risk assessment in place to guide staff as to what were the risk factors for someone with diabetes, the symptoms of high or low blood sugars or the actions they would take if a person appeared unwell. Another person took medication that gave them a risk of excessive bleeding or bruising. There were no risk assessments in place to direct staff as to what precautions or actions to take. Staff described to us the difficulties that they had on occasions when a person was found on the floor and they required assistance to stand. There was no risk management plan to direct staff as to what actions to take in any given situation or how to safely help a person to stand if this was appropriate. This meant that there was a risk that staff may not provide the right level of support or oversight.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider had not ensured that processes were in place to assess, monitor and mitigate the risks relating to people who used the service.

Staff at the service understood about safeguarding and what constituted abuse or neglect. The registered provider had their own safeguarding policy as well as that of the local authority. These documents were readily available and accessible to staff. There was evidence that staff had highlighted concerns appropriately and were confident in approaching the management of the service with any issues. Staff told us that they were not afraid to speak up because the people supported must come first and that everyone deserved a really high level of care. Records showed that the registered manager took action where required to review and investigate incidents so that lessons could be learnt and the service continually improved.

Staff provided varying degrees of support to a number of people in regards to the ordering, administration and disposal of medication. There was a process in place for staff to follow to assist them to do this safely and staff were provided with an appropriate level of training. This included specific training and observation where medication was given by a specific route such as eye drops or the application of creams.

People confirmed that staff helped them with their medication and ensured that they had them at the right time and in the right way. One person commented "My health is far better since I came here because now I get reminded that I need to take my tablets on time". The level of support required was recorded in a person's support plan and people had signed, at a time that they had capacity, to consent to this task. We checked the Medication Administration Records (MAR) against the stock of medicines stored and found

them to be accurate.

Some medications are prescribed to be given "as needed or as the situation arises" (PRN.) Some of these were in a variable dose but staff did not always record how much medicine was given and at what time where a variable dose was prescribed. There was a care plan for some, but not all PRN medications, to guide staff as to when it should be given or offered. It is important that this information is recorded and readily available to ensure people are given their medicines consistently. This had already been highlighted as an area of improvement by the registered manager and a memo sent to staff on the 23 May 2016.

People told us that "Staff always comes but they are so busy these days they don't have a minute spare". We were informed that the registered manager had changed shift patterns earlier in the year to ensure that an additional member of staff was available at busy times of the day. Staff felt that this had improved matters but that they sometimes struggled on those occasions or periods where a person might require short term additional support. On the days of the inspection, two people were unwell and required two staff to assist with personal care or mobility needs: this meant that during those periods staff were limited in their ability to respond to meet the planned or unpredicted needs of others promptly. Staff were also called to assist in the Bistro as staff, linked to the meal service, had failed to come across to serve. This meant that there was a short delay for people who required lunch calls in their apartments. Following the inspection, we spoke to the registered manager and the area manager about their contingency plans and need to ensure that staffing levels can be responsive in such circumstances.

Accidents and other incidents were reported to the registered manager. There was a process in place called "Time critical reporting". This ensured that staff were aware of what they needed to report and to whom. Incidents were then analysed by the registered manager to see if any lessons could be learnt in order to minimise further risk of harm. These matters were also reported to the registered provider so that wider themes and trends within the service could be identified and further explored.

We checked the recruitment procedures in place for staff. The registered provider had policies in place to support safe recruitment for all new staff. We found that all the required checks had taken place prior to staff commencing employment: fully completed application form, interview notes, written references and a Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. This meant that people received support from staff deemed to be of suitable character and skills.

The care provider was also the housing provider. Appropriate checks were carried out and they maintained overall responsibility for the health and safety of the premises. People told us that they were quite responsive in sorting out any issues with the building or apartments. There was an emergency plan accessible that indicated the location of the electricity supply, mains gas, and the water valves in case of an emergency. This meant that the premise was adequately maintained.

A Fire risk assessment had been carried out and the service had recently been inspected by the fire service. Each person also had a personal evacuation plan in place in case of an emergency to establish what help and support they would require to leave the building and we saw that these were reflective of a persons needs.

Is the service effective?

Our findings

People had confidence in the staff and told us that "They know what they are doing: they are quite skilled". People said that staff enabled them to remain in their own homes because they had the help and support they required.

People commented "Staff help me to make whatever I fancy to eat" and "They help me draw up a list of things so that my family can go out and get them". Staff supported some people to ensure that they received adequate diet and fluid intake. Not everyone was able to make a meal for themselves and so staff helped with the preparation or assisted a person to go to the bistro if this was their choice. Daily records indicated that staff prepared a variety of foods at a person's request and also helped them to draw up shopping lists and meal planners for the week ahead. Where concerns about a person's diet or fluid intake had been identified, staff kept a record to assist families and other professionals in monitoring what a person had been offered and consumed whilst supported. We saw that agreement had been reached with a health professional to provide hourly prompts to a person during a period of ill-health to ensure that they had sufficient fluids. Daily records indicated that during the hot weather staff encouraged extra drinks as they had acknowledged the importance of keeping hydrated. Staff also supported people to ensure that their food was in date and stored appropriately. Staff had completed food hygiene certificates which meant that they had the knowledge to support people safely in the kitchen.

The registered provider had a supervision and appraisal policy that set out the expectation of both the employer and the employee. Staff confirmed that they had regular one to one meetings with the registered manager and that they found these beneficial. Each staff member had an annual appraisal which gave them an opportunity to review and discuss their own developmental needs. Records viewed confirmed that these had taken place and had been effective.

There was a robust induction programme for new staff that met the requirements of the Care Certificate. This is a set of fundamental standards that social care workers should adhere to in their daily working life. Staff told us that they felt that the induction had prepared them well for the job and that they really appreciated time spent learning from experienced staff. Records indicated that staff had more regular performance reviews during an initial six month probationary period to ensure that they had developed competence and confidence in their role. At times, the service utilised agency staff to cover gaps. There was a check list in place for them so that they were orientated to the service and the building.

The registered provider had a training programme for staff that covered all of the key aspects of the role. Training was a combination of e-learning modules and face to face sessions. The registered manager maintained a record of staff training that had been completed as well as that pending; so they were aware of the requirements for all staff. Staff had undertaken training that the registered provider had deemed essential to their roles: such as medication administration, moving and handling, safeguarding and mental capacity. However, they also had opportunity to undertake additional training for areas of specific interest such as end of life care or dementia awareness. One staff member told us about an extended course on dementia that they had been undertaking as many people within the scheme were living with dementia.

They had felt it important to know about best practice and how to support people in the right way. Staff said that the training gave them the knowledge and confidence to provide good care.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA. Where people live in their own homes, in the community, applications must be made to the Court of Protection. At the time of our visit to The Hawthorns no one was being deprived of their liberty and no applications had been made to the Court of Protection.

From our observations and discussions with staff it was identified that a number of people had memory loss which impacted on their ability to make decisions for themselves. We found that staff had undertaken training around the principles of the Mental Capacity Act 2005. Staff were able to tell us what they understood by mental capacity and consent and gave examples of how this related to their day to day work. One staff member spoke passionately about the importance enabling and supporting people to make choices. They explained how they tried to help people to make choices and sometimes offered just few little things not to overload a person. Staff recognised that it was really important for a person's self-esteem not to disempower them. Daily notes provided good examples of staff offering and assisting a person with a choice of foods, clothing's, tasks and routine. Staff also recorded where a person had refused support and the reasons why.

Some people's ability to make decisions had changed over the course of their tenancy at The Hawthorns. Staff described to us situations where they needed to make decisions on behalf of people but were clear that they did this "Always in a person's best interest". However, we found that care plans lacked information about a person's capacity to specific decisions. Where actions needed to be taken in their best interests, these were not always clearly recorded in the care plan. We found that, on occasions, a relative had been asked to sign and consent on a person's behalf but there was no evidence if that person held a Lasting Power of Attorney. A Lasting Power of Attorney (LPA) is a legal document that lets a person appoint one or more people to help them make decisions or to authorise decisions on their behalf.

We recommend that the service seek advice and guidance about recording and evidencing decisions about care, treatment and support in regards to a person's mental capacity.

Other people told us that staff always asked their permission and consent in decisions around their care and support. Comments included "They always ask me before they do anything to make sure that it's what I want" and "They will always check before they ring my family or the Doctor to make sure I am happy with that".

People told us that staff contacted health and social care professionals on their behalf to ensure that they kept well. Daily notes documented where staff had sought advice from external professionals. On the day of the inspection, we observed a staff member in negotiation with a local GP as they were concerned about the health and wellbeing of two people who lived within the scheme. They demonstrated a good awareness and knowledge of the person and the factors impacting on their health that had led to the request.

Is the service caring?

Our findings

People were very complimentary about the staff and all commented on their "Caring and patient" approach. One person said "My carer is marvellous. They are so understanding and caring. I can talk to them about all of my worries" and another commented "It's not just with me, but everyone. Staff are so patient with people who are really forgetful and get lost. They never ignore them".

However, we found that on occasion, the service did not ensure that a person's preferences as to who delivered their care was respected. At night, the service had a lone worker and sometimes this was a male. Daily records indicated that people were not comfortable to receive intimate care from someone of the opposite sex but had not been offered a choice. Daily notes for one person indicated "[name] asked me if a female care could help them undress later" and another recorded "[name] is a little apprehensive about their care being provided by a male carer tomorrow but I have assured her that it will be fine." The male carer attended on three consecutive days to find the person had got up early to do it for themselves. We spoke to the person who confirmed that they had not been offered the choice to receive their care later in the day from a female and said "I draw the line at letting a man help me with intimate things, it's not right". People's preferences and wishes should be explored and recorded in their care plan agreements. When providing intimate care, the registered provider should make every reasonable effort to make sure that they respect a person's preferences.

This was a breach of Regulation 10 and 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 because the registered provider should ensure that service users are treated with dignity and respect at all times. Peoples preferences should be clearly recorded and respected.

Records were kept securely within locked cupboards and were available only to those people that required them. Staff ensured that the office door was locked when they left it to go somewhere in the building. We brought to the attention of the registered manager that it was not deemed appropriate to have person's "Do Not Resuscitate" order pinned to the notice board in the staff office and asked that it be removed a stored more appropriately to ensure that the person's confidentiality of information is upheld.

People said staff were "Patient and kind". They appreciated that they had a small and consistent staff team and this gave them confidence. Any new staff were introduced and one person commented that "It's not long before they get to know you and all of your routines and then it is easier all round". People spoke about the care they received positively and said that it "Made a difference": they made comments such as staff "Help me to help myself", "Staff encourage me to be independent and to do as much as I can for myself" and "They are really flexible if I need to change times because I have family visiting or want to go out".

People said that staff responded quickly to them but were conscious that at times they were very busy. Staff not only supported those in receipt of personal care but also those who utilised the call bell service. We observed that calls were constant with some people calling repeatedly because they had forgotten previous calls. Staff were extremely patient in their response and always went to check. Staff explained that the one

time you failed to attend could be the very time that person was really in trouble. Throughout the days of the inspection, people came down to the communal areas and due to mobility or cognitive impairment often required the assistance of staff passing by. Staff always acknowledged a person and gave them the support and reassurance that they needed.

People said of the staff "They are not intrusive and are fully aware that they are coming into my own home". Staff recognised that although people lived in a communal setting, they had a right over who came into their property and when. Staff were observed to knock-on somebody's front door and to wait for a person to come to open it for them. Where a person could not answer the door, staff used a key to enter but this was only with prior expressed consent which had been recorded in their care plan at the start of the service.

The service was part of the Methodist Homes Association (MHA) and part of the ethos is to support a person's spirituality. A chaplain visited the service a number of days a week and chaplaincy is a long and honoured tradition within the MHA. Their role is to offer individual pastoral care and an opportunity for those people who wish to engage in worship and faith-based activities. A number of people we spoke to said this was very important to them and that they appreciated being able to speak to the chaplain and that this helped them to meet their own religious needs. Others were supported to get ready to attend local churches or to receive ministry within their own homes.

A program called the 'final lap' had been introduced within the service. This was an end of life programme designed to help people to speak openly and honestly about death and dying. The majority people use the service had not completed this information with the staff at the point of starting the service but we were told that it was revisited at each review.

People were given information that was of relevance about the service and had a copy of their care plan in their own homes for information. People also had notification of things of interest happening within the scheme or in the local community. This was done with via staff communication, tenants meetings, use of the notice board or leaflets and posters.

Is the service responsive?

Our findings

People were keen to tell us that staff were "reliable", "kind", "helpful" and helped to "maintained independence". One person told us that they received low level support at the time but that "The staff about are so helpful and responsive, I would have no hesitation in receiving more personal care when the time comes".

Each person had a care plan in place that should direct staff as to how to meet a person's needs in line with their wishes and preferences. We found that care plans lacked the detail that would allow staff to readily understand how to deliver a person's care. Care plans did not indicate the exact level of support a person required or what they could do for themselves. Care plans contained generalised statements such as "assist with full wash", "prepare a meal", "administer medication", "assist address or undress". Some people required help to maintain their continence however records did not indicate whether people suffered with urinary or faecal incontinence, what products they used, or how staff were to help them maintain their independence.

Care plans were not always updated to reflect a person's change. Daily notes indicated that a number of people had received assessment from external professionals. For example, a person had been visited by a health professional and it was deemed that they were at risk of dehydration. An agreement was reached with staff for hourly prompts of fluids which had taken place. However, a review of their nutritional needs assessment around the same period indicated that there were no concerns around hydration or nutrition and they were not at risk. Another person had been seen by the speech and language team and clear instructions left for staff. Again, daily notes indicated that staff had followed instruction, but the information was not contained or written into a care plan or risk assessment. One person had been seen by the dietician who deemed them at risk of malnutrition but care plan had not been revised to include their guidance and to indicate what changes to diet or types of foods were required.

A very detailed daily log was kept of the care provided. This evidenced that what support had been offered, accepted and refused. It also recorded the times of the visits so that people were only charged for care received. Staff recorded information about changes or observations about a person's health and wellbeing but did not formulate this into a care plan. For example there was great detail about a person's swollen feet, weight gain, breathlessness and skincare contained within daily notes. It was clear that staff provided the correct support and oversight recommended by the GP and had taken action to address these issues. However, there was no indication of these concerns or management plans within care plans or risk assessments.

Some people exhibited behaviours that challenged staff and others. Staff were able to describe these to us and to explain how best to intervene. However, care plans did not indicate or establish any triggers for such behaviours, how they may present themselves or what action to take. Records did not always show an understanding of a person's behaviour or mood: we read comments such as "[Name] can be tearful in the morning but snaps out of it" or "[Name] does not enjoy things but does not refuse and then gets upset". There was no indication as to what things the person did not enjoy in order for staff to avoid this distress to

the person.

Words such as "Aggressive", "Violent", "Blunt" "Worked up" and "Needy" were used to describe people: rather than explaining what behaviours or emotions were demonstrated. The area manager told us that they had documentation available to record and analyse behaviours but there was no evidence that this had been used. There was a risk that staff less familiar with a person would not have the information they required to provide a safe and consistent approach.

These were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider must ensure that an accurate and complete record is held for each person.

Staff were clear each day what roles and responsibilities they had for a shift and which people they were to support. They told us that a "key worker" system was due to be introduced in order to give clear lines of responsibility. Information was handed over verbally during and between shifts. Staff completed a communication book which detailed key changes to a person's health, care plan, or routine. This ensured that staff were fully up to date with what a person required on that particular day.

People were provided with a call pendant that allowed them to call for additional help in case of an emergency. Staff also carried handset that enabled them to call each other for help should they find a person required additional help or support.

There was a policy in place for the recording and investigation of complaints. This indicated that "You may refer the complaint to one of the following bodies" which included the CQC. This needed to be reviewed to reflect accurately the role of CQC. None of the people that we spoke with had cause to raise a concern or complaint about the service. They were aware of how to do this and told us that they would have "No hesitation in raising a concern" and felt "Assured that it will be dealt with."

We spoke with staff and the registered manager about the expectations that tenants, family and professionals have of Extra Care Housing. It was clear during the inspection that some viewed the service as a care home which it was not. Staff explained that they had to be clear about the roles and boundaries but that this was sometimes difficult. We saw that the registered manager was proactive in identifying situations where they could no longer meet a person's needs and to seek a reassessment of the support commissioned or required.

The service recognised that people were at risk of social isolation and loneliness. Staff understood the importance of social contact and companionship. The service enabled people to carry out person-centred activities and encouraged them to maintain hobbies and interests. Staff supported people with poor mobility or memory loss to participate in activities that took place in communal areas such as coffee mornings, afternoon tea, film nights and arts/crafts. Staff were proactive and made sure that people were able to keep up relationships that mattered to them, such as family, community and other social links.

Is the service well-led?

Our findings

People said that the setting in which they lived was "Well managed" and that "There was usually someone in the office that you could raise an issue with". People had "No complaints" about the service and in their opinion the service was "Excellent", "Well-run" and "Managed fine".

There was a manager in place who had been registered with the CQC since February 2016. Staff reported confidence in the registered manager and commented upon his professionalism. They said that since he had come into post he had made a difference to the running of the service. Staff appreciated his management style and felt he was fair and equitable. Staff felt that they could speak to him about any issues because he would hold their confidence, listen and take action. One person told us that they had never worked in care but the registered manager had given them every confidence that they could succeed.

The registered manager was away during the inspection but had prepared the staff in the event of the CQC attending the premises. Staff were able to speak to us about the service, its management and direct us to where any of the required documents were located. This meant that the service was able to run smoothly in the short term absence of the manager.

Staff said that now worked better as a team and pulled together in difficult times. A new member of staff told us that it was good to work with a team that were knowledgeable and that there really was a "community spirit" within the scheme. Staff appreciated that they were thanked and complemented when they did something well. We saw that the registered manager had written to a member of staff to thank them for the quick response during an emergency situation and that the input was very much appreciated. Staff were encouraged to raise concerns with the registered manager. Where this had occurred, staff were praised and actions taken to ensure that they were listened to.

The registered provider had policies in place to guide and advise the staff in their day to day jobs. These had recently been revised and staff were in the process of reading these and signing to say that they were familiar with them. A policy and procedures folder was in place in the office and additional key information kept in the office. Staff were aware of where this was kept and confirmed that they were informed of changes. Staff were provided with terms and conditions of employment which included their hours of work, leave, data protection, code of conduct etc. These had recently been re-issued following a consultation around changes to shift patterns, pay and benefits. Staff confirmed that they were engaged with any consultations processes relevant to their employment.

There was a series of audits in place to monitor the overall quality and safety of the service. These were completed by the registered provider and the registered manager. The medication audits had been effective in highlighting areas where improvement was required and there was evidence that learning had taken place. For example: the registered manager had observed that staff had been 'potting up' medication for another staff member to administer. Secondary dispensing is not a recommended practice and so he had taken action to address this and a memo had been issued to all staff. Issues with recording had also been addressed.

However, although care plans and risk assessments had been regularly audited by the registered manager and registered provider, this had not been effective in identifying the issues we found during this inspection in regards to records, risk assessments or the delivery of care in line with wishes and preferences,

We recommend that the registered provider review the robustness of the audit systems that it has in place to ensure that issues around reviews and record keeping are identified, monitored and addressed.

People had access to a pendant by which they could call staff at any time of the day or night. These call logs were printed out so that the registered manager could analyse the number of times that a person called but also the response time of staff. Repeated calls were an indication that a person's care plan needed to be reviewed. We found that this was done swiftly with appropriate referrals being made to service commissioners or meetings held with the person and family to enable a review of the care package.

The housing provider held regular meetings with tenants to discuss issues with regards to their tenancy. The registered manager attended the meeting so that people were able to discuss any issues or concerns relating directly to care provision. Regular staff meetings were also held and the minutes of which demonstrated that a wide range of topics were discussed from concerns about tenants, staffing issues, staff performance and best practice: including CQC inspections.

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	<p>Regulation 10 HSCA RA Regulations 2014 Dignity and respect</p> <p>The registered provider did not ensure that service users were treated with dignity and respect at all times. When providing intimate care, they should make every reasonable effort to make sure that they respect a person's preferences.</p>
Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The registered provider had not ensured that processes were in place to assess, monitor and mitigate the risks relating to people who used the service. The registered provider did not ensure that an accurate and complete record was held for each person.</p>