Orbit Group Limited

Childwick House

Inspection report

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27 October 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 24 and 27 October 2016. The first inspection visit was unannounced but we informed the provider we would be returning for a further visit on the 27 October.

The service provides extra care housing for people living in each of the 24 flats within the same secure building. At the time of our inspection 23 people were resident. Staff are onsite 24 hours a day and people who use the service are able to summon help outside of their normal contracted care visits by using a call bell system. Although aspects of the service operate in a very similar way to a registered care home, the Care Quality Commission only regulate the provision of personal care in services such as this.

There was a registered manager in post. 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.

Staff had received training in safeguarding people from abuse. Staff mostly understood their responsibilities in this area but we found that some matters had not been appropriately referred to the local authority for investigation or notified to us.

The service assessed risks people faced but information was not comprehensive and some risks had not been assessed. There was insufficient guidance for staff to follow in order to reduce the likelihood of some risks.

Staffing levels were assessed but the service did not always operate in line with this. Staffing was recognised as a concern and action had been taken to try to ensure consistent staffing as much as possible.

Medicines were not always administered safely and errors were identified which placed people at risk of harm. Records related to medicines were not clear and the provider addressed this issue by the time of our second inspection visit.

Training and support was provided for staff to help them carry out their roles and increase their knowledge. There was an induction process in place but records of people's progress were not all complete.

People gave their consent before care and treatment was provided and staff had received training in the Mental Capacity Act (MCA) 2005. The MCA ensures that, where people lack capacity to make decisions for themselves, decisions are made in their best interests according to a structured process.

People were supported with their eating and drinking and staff helped to ensure that people had access to the food and drink they might need after staff had left for their next call. Staff also supported people with their day to day health needs and worked in partnership with other healthcare professionals. Information in

care plans relating to health conditions did not give staff clear guidance about people's specific needs.

Staff were caring and people were treated respectfully and their dignity was maintained. Relationships between the staff and those they were caring for and supporting were very good and agency staff were used as consistently as possible to try to minimise concerns people had regarding staff not being familiar with their needs. There was a strong sense of community amongst the people who used the service and this was important to them.

People were involved in planning and reviewing their own care and were encouraged to provide feedback about the service. There was a commitment to preserving people's own skills and maintaining their independence.

Although the service sought to provide individualised care which met people's changing needs this was not always possible due to the staffing levels in place. As people's needs reached a particular threshold they were supported to move on to other accommodation.

A formal complaints procedure was in place but none had been received. Informal complaints were dealt with appropriately.

Staff understood their roles and were supported by the management team. There was an open culture which staff and people using the service valued. Staff shortages had meant that management time had been reduced on occasions and the registered manager had not had clear oversight of all the issues facing the service.

Comprehensive quality assurance systems were in place to monitor the delivery of the service but some of these were not effective.

We found breaches of regulations during this inspection. You can see what action we have told the provider to take at the back 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?

Requires Improvement

The service was not always safe.

Staff were trained in safeguarding people from abuse and understood their responsibilities but appropriate referrals had not always been made to the local authority.

Risks were assessed but information was brief and not all risks had been considered.

The service did not always operate in accordance with its assessed safe staffing levels.

Medicines were not always administered safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were provided with appropriate training.

People gave their consent before care was provided and staff had an understanding of the MCA.

The service supported people to maintain a good diet and to look after their health but information about people's health conditions was not sufficient to guide staff and ensure they provided consistent and effective care.

Is the service caring?

Good

The service was caring.

Staff knew the people they were caring for well.

People who used the service, and their relatives, were very positive about the way the staff provided care.

Staff were kind and treated people with respect, maintained their dignity and promoted independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were involved in assessing and planning their care but the needs of people with complex health problems or deteriorating conditions could not always be met.

Care plans provided brief information for staff and did not always document preferences and specific requirements.

The service actively sought out people's views and any complaints were responded to appropriately and promptly.

Is the service well-led?

Requires Improvement

The service was not always well led.

Required notifications had not been sent to CQC and to the local authority in response to some incidents.

People who used the service and staff were involved in developing the service.

Staff understood their roles and felt well supported but management time was not protected.

Quality assurance systems were in place to monitor the delivery of the service but these were not always effective.

Childwick House

Detailed findings

Background to this inspection

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

The inspection took place on 24 October 2016, when an unannounced visit was carried out. We also carried out a second visit on 27 October 2016. This visit was announced.

The inspection team consisted of one inspector and one 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. Our expert had experience of services for older people and carried out the first of the inspection visits with us.

Before we carried out our inspection we reviewed the information we held about the service. This included any statutory notifications that had been sent to us. A notification is information about important events which the service is required to send us by law. We also reviewed the 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.

We spoke with ten people who used the service, four relatives of people who used the service, three care staff, two agency care staff, the senior team leader who was in day to day charge and the registered manager. We also spoke with one adult social care professional from the local authority older people's team.

We reviewed six people's care plans, six medication records, one staff recruitment file, staffing rotas and records related to the monitoring of the quality and safety of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe using the service. One person said, "In general I feel safe and comfortable here". Another person explained, "I am secure because I feel the staff are doing their best to make sure everything is all right for us". This feeling was echoed by nearly all the people we spoke with including relatives. One commented, "The place is perfect for [my relative]. [They] have a degree of independence while knowing someone is keeping an eye on [them]". However some people with higher care needs did not always feel their safety and comfort was safeguarded and expressed some reservations. One person said, "Most of the time I feel safe but those of us who need a greater degree of support it's not so good, especially when you have a carer who doesn't know you".

Risks to people's health and welfare had been assessed. We viewed risk assessments related to people's moving and handling needs, the provision of bedrails and taking medicines. Some specific risks had been considered such as one person's blurred vision following the administration of eye drops which put them at increased risk of falls. However some risk assessments, relating to people's more complex needs, did not always go into sufficient depth. For example one person's moving and handling risk assessment stated, 'Follow all training for moving and handling at all times'. The assessment had been written in June 2015 and was subject to a three monthly review but this had not taken place. This meant we could not be assured that this person's changing needs had been assessed.

Given the high numbers of agency staff who would not be as familiar with people's needs, risk assessments did not ensure staff were aware of all potential risks and knew what action to take. Where a person had been prescribed a blood thinning medicine, risks associated with this had been documented but did not cover what to do if the person had a fall. Such a fall could result in excessive bleeding. We saw that the person had sustained some falls but no specific action had been taken in response to this increased risk. The accident reports stated that a care staff member had assessed them as having 'no apparent injuries'.

Other falls were managed in a similar way and care staff, whose training was a basic first aid course, assessed people's injuries and then used the hoist to raise them from the floor if they were unable to get back up. The service had communal hoists and slings of different sizes. Although the correct size to use was not documented in each person's moving and handling risk assessment, we found that staff were aware of the need to make sure they had the correct sized sling. This would have been clearer if it had been documented for staff.

One person's risk assessment for being moved with the hoist stated that two staff should carry out this manoeuvre. The person told us that sometimes staff do this on their own and they did not feel safe. A member of staff confirmed that sometimes staff do carry this out on their own. We fed back this concern to the manager who told us they would discuss this with their staff.

Some risks had not been assessed. For example one person's daily notes recorded that their behaviour presented a possible risk to staff but there was no risk assessment related to this. Specific risks relating to people's progressive health conditions, such as Parkinson's disease and dementia, had not been assessed.

This was a breach of the Health and Social Care Act 2008 Regulated Activities Regulations (2014) – Regulation 12 (1), (2) (a).

Although CQC only regulate the delivery of personal care at this service we saw that the risk of fire had been assessed and each person had a personal emergency evacuation plan. We found these to have little detail and often made note that the person was 'not able to manage the stairs' without making clear what actions staff should take in the event of a fire. There were no evacuation chairs to help bring people down the stairs and staff we spoke with understood themselves to have a responsibility to evacuate the building but were not clear exactly how this would be achieved. We have forwarded these matters on to the fire service to discuss with the provider.

Medicines were not always well managed by the service and systems did not protect people. This was mainly the case for people who had more complex medication arrangements. Those people who only required prompting to take their medicines were satisfied with the help they received. Information about what people's medicines were for and how they liked to take them was not comprehensive. Clear protocols were not in place for PRN medicines. These medicines are given only occasionally and not on a consistent basis, such as paracetamol for pain relief.

We saw that risks associated with people taking their own medicines had been assessed and the service worked with people and their families to support those who wanted to remain independent in this area of their life. Where people were supported to manage their medicines we noted that prescribed medicines were made available quickly. For example staff noted that a person's eyes were weeping and called the GP who diagnosed an eye infection. Eye drops were prescribed and the course started the same day.

Several people were supported with all the ordering, storage, administration and disposal of their medicines. Staff received training before they supported people to take their medicines but their competency to do this was not checked. This was also the case for agency staff. On the day of our inspection a new member of staff was administering medicines along with an agency member of staff. Both had received training, although this was not recorded on either's record and the service had not confirmed with the agency that the agency staff member had undergone the required training successfully. Neither person's competency to administer medicines had been checked by the manager or a senior member of staff. The new staff member was due to undergo such a competency check but this had not yet taken place. The provider's own medication policy states that such a competency check should take place before the staff member can independently support people to take their medicines.

One person told us that they had not been consistently supported to have their eye drops and records confirmed this. We also found errors in the administration of one person's medicines which included blood thinning medicine which was subject to frequent changes in dose. We checked the stock of this medicine and found records were confusing and did not give staff clear information. The recorded amount of stock did not match the actual amount of medicines in stock which meant that the person had not always received the correct dose. This could have had a serious impact on their health. Stocktaking measures for this, and other, medicines were not robust and meant we were unable to determine when any administration errors may have occurred. The manager in day to day charge agreed that the administration procedures were not robust and devised a new stocktaking and administration form by the time we carried out our second inspection visit. Whilst this was a good response we were concerned that medication audits had not identified this issue previously.

This was a breach of the Health and Social Care Act 2008 Regulated Activities Regulations (2014) – Regulation 12 (1), (2) (g).

Recruitment records showed that staff had followed an application process, been interviewed, had their identity checked and had their suitability to work with this client group checked with the Disclosure and Barring Service. Robust checks of people's references had been carried out by the provider's HR department and any concerns or queries shared with the registered manager.

We were already aware that the service had struggled to recruit and retain staff over the last year. This had resulted in a very high number of agency staff working at the service and, overall, people were not happy about this. A meeting had recently been held to discuss this issue and explain how the service planned to make improvements but some people remained concerned. We saw that in August 2016 over 50% of shifts had been operated by agency staff. Individual agency staff members were highly praised by many people and those we spoke with were skilled and knowledgeable.

The registered manager confirmed that staffing remains a concern to them. They told us that two care staff and one senior should be on each shift until 16.30 when the senior staff member finished and two care staff remained. At night there was one waking staff member and a person carried out a sleep in shift and could give help if needed. Rotas showed that shifts had operated with less than this number of staff on several occasions in the last three months. We noted that the senior on duty, who we were told was intended to complement the other two staff, actually worked a shift, meaning that only two rather than three staff were on duty. This was more often an issue at weekends, although we did note that the issue had improved since the summer. We also noted that there were three occasions in the last three months when agency staff were on duty together and this was the case on the second day of our inspection.

One person, who required two people to help them with their moving and handling needs, told us that occasionally only one member of staff had carried this out and they did not feel safe. Staff confirmed that this sometimes happened. From 16.30 onwards, when only two staff were on duty, staffing levels were low. If both were supporting one person either with an emergency or to help them with their moving and handling needs, this presented a potential risk to other people who used the service. This was because there would be no staff available to help them until they finished providing support.

This was a breach of the Health and Social Care Act 2008 Regulated Activities Regulations (2014) – Regulation 18 (1).

An out of hours on call service was in operation and covered the entire Orbit organisation. Staff were aware of this but both they and the registered manager had reservations about it as the person on duty may be from a housing background and could not be relied upon to give advice to staff if they had a query relating to health and social care matters. One staff member told us that staff often do not bother to contact the out of hours service and instead ring off duty senior staff which is clearly not best practice. The registered manager told us they had raised their concerns about this matter but so far no action had been taken as a result.

Most people, however, did not feel that the staffing levels had a negative impact on them. All the people we spoke with praised the staff response when they pressed their emergency cords to summon help. We received comments such as, "If I pull my cord they are not long before they are there to check up on me" and, "When I last pulled the bell someone came straightaway". One person said, "I have fallen and pressed the buzzer. It wasn't long before someone put their head round the door". People also told us they usually receive their medicines and care visits on time, although some did comment that calls can be a little late. Two people told us about occasional times they had failed to receive a care visit. We were satisfied that this was not a routine occurrence and people were clear that they could press their emergency pendants if they needed help urgently, and one person told us they had done this and staff had come promptly to support

them.

We found that systems were in place to reduce the risk of abuse and to ensure that staff knew how to spot the signs of abuse and take appropriate action. Staff had received training in safeguarding people from abuse and were able to tell us what they would do if they suspected or witnessed any of the different forms of abuse. Staff knew how to report concerns within the company and information about how to make a safeguarding referral to the local authority was available.

During the course of our inspection we identified some incidents, including medication errors and an episode where a person did not receive prompt medical care, for which it would have been appropriate to make a safeguarding referral so that the local authority could carry out an investigation. We discussed these with the manager and they confirmed that they had not considered the incidents required reporting and had carried out an internal investigation and taken disciplinary action. Information and advice is freely available from the local authority Multi Agency Safeguarding Hub (MASH) to establish if a matter should be reported as a safeguarding issue or not.

Requires Improvement

Is the service effective?

Our findings

The majority of the people we spoke with were very positive about the care provided and about the skills and competence of the staff, although some were concerned about the use of agency staff. One person who used the service said, "The carers seem to know what they are doing" and a relative commented, "They encourage my [relative] to do things for [themselves]". Others expressed concerns about the skills and knowledge of some agency staff. One person said, "I have to tell the agency staff what to do – they just don't understand what I need". A relative also expressed a reservation saying, "Staff know what [my relative's] needs are and support [them] well. The agency staff aren't always so good because they don't know [them]". We noted that agency staff who had worked at the service for a number of shifts were highly praised by some of the people who used the service.

Staff received an induction when they started to work at the service. One person told us, "I did two weeks of shadow shifts and had moving and handling and meds training". We asked how they learned about people's needs and they confirmed that they mainly asked people about their needs and asked staff. They did not rely on care plans. We noted that records related to their induction were mostly blank so we were not able to confirm all the information they told us about their induction.

Permanent staff undertook a wide range of training and this was appropriately refreshed to ensure their knowledge was up to date. Training, such as basic life support, dementia, fire safety, medication, food hygiene, infection control and moving and handling were provided alongside specific courses such as cash handling. We found staff, including agency staff we spoke with, to have the skills and knowledge required to provide day to day support.

Agency staff received a brief induction and a checklist was completed to confirm they had read certain important information including the medication policy. We saw two completed induction checklists for agency staff on duty on the day of our inspection. One staff member confirmed to us that they had been able to shadow a permanent member of staff on their first shift and were becoming familiar with people's routines and preferences after completing a few shifts at the service. They praised the quality of the verbal handovers between each shift and we saw that there were good written communication systems in place designed to promote consistent care.

The management and care staff demonstrated an understanding of the Mental Capacity Act (MCA) 2005, and staff had received training in this. The MCA ensures that if people do not have the capacity to consent for themselves the appropriate professionals and relatives or legal representatives should be involved to ensure that decisions are taken in people's best interests. People told us they had been involved in decisions about their care and indicated their consent although we found care plans and risk assessments had not been signed to confirm this. Relatives had been appropriately involved in decisions about people's care. One relative told us, "They always ask permission before doing anything for my [relative]". Staff were clear about the need to establish people's consent before care and treatment was provided and were able to describe what action they would take if a person refused care. Staff showed an understanding of people's rights.

We observed that staff encouraged and supported people to prepare and eat their meals and ensured they had access to food and drink once the care staff had left. Staff supported people to eat at an appropriate pace without rushing them. Care plans contained minimal guidance for staff to follow and staff told us they relied on people to tell them what they required. One person, who was at risk of not eating and drinking enough told us, "I'm trying to put [weight] on. I get some meals with cream on". Staff were aware of this person's individual needs and we observed them encouraging the person to eat well.

People told us that staff supported them with their healthcare needs and worked well with other healthcare professionals such as GPs and district nurses. We saw from records that people were referred very promptly to the appropriate healthcare professionals if they became unwell and staff communicated effectively with each other to monitor the health of any person they were concerned about. One person said, "When I was ill and asked for a doctor it was done immediately". Another person confirmed, "If I need a doctor they are on the phone sorting it out". We also observed this during our inspection visit.

During our inspection we were made aware of an incident where someone had not been provided with prompt healthcare support and this had had a serious effect on their health. The matter had been addressed with the staff concerned through the disciplinary process. We judged that the basic level of information in care plans about people's healthcare needs meant that plans did not give sufficient guidance to staff. We raised this issue with the manager.

We saw that sometimes records relating to a person's healthcare appointments were not complete. For example we saw that there was a record that one person had received a visit from a specialist but there was no further information about the result of such a visit even though we were aware that the service worked closely with this healthcare professional to support this person's particular health needs. We also saw similar issues in two other care plans.

Good

Is the service caring?

Our findings

People who used the service, and their relatives, were very happy with the way care and support was provided and all those we spoke with praised the caring attitudes of the staff. One person who used the service said, "We talk about television, the weather or things that happened years ago. I like all of that and it makes me feel cheerful. I feel I am a real person with feelings to them". Another person said, "The carers never have an unkind word to say. They never get het up or angry; they stay nice and calm". A third person commented, "The staff are very nice and polite and show me respect and value me as a person". Relatives were equally positive with one commenting, "[The staff] give me peace of mind – I don't have to worry. I can't thank them enough for looking after [my relative]".

We found staff were patient, kind and caring in their interactions with people and showed an interest in the people they were caring for which was far from being 'task led'. There was time for staff to chat to people and have a laugh and a joke. One person commented, "I have a good laugh with the regular staff in particular -It lifts your spirits when you have a relationship with the staff. They are respectful and acknowledge me".

Regular staff knew the people they were supporting and caring for very well and were able to tell us about people's histories, preferences and their care and support needs. Each person had a visit that was long enough for staff not to be too rushed. Some visits were very short and could last only seven and a half minutes but these were monitoring visits where staff did things like opening the curtains and making a cup of tea. Even during these very short visits people told us staff were able to have a chat with them. One person commented, "They may only pop in but there's still time for a conversation".

Agency staff were not held in high regard, with one person saying, "The agency carers, especially the young ones, don't seem to care". Agency carers on during our inspection visits were much praised but people told us they had experienced a high number of agency staff over the last few months and feedback had not been positive.

People told us that they felt the service kept them informed about matters that concerned them. A recent meeting had been held to address people's concerns about the high usage of agency staff and to try to reassure people that plans were in place to reduce this. We saw that the service had been trying to ensure that agency staff were used consistently so they could become familiar with people's needs and particular routines but this was not always possible.

People were involved in decisions about their care and their opinions were sought although they were not always clearly recorded. Some people were not aware that they had a care plan but this was not considered an issue for them as often their care visits were short social visits to check on their welfare. One person said, "My care plan is around somewhere. It was discussed with me I think".

Where people's needs were more complex we saw that the service had worked with the person and their family to establish what people's needs and preferences were. Advocates were not promoted as all the

people we spoke with told us they had family to help advocate for them if they needed this and other people were competent self-advocates.

We observed staff respectfully knocking and waiting to be invited in to people's flats. People told us that staff treated them respectfully and maintained their dignity when giving personal care for example. People were encouraged to maintain their independence. One person told us, "I do need a lot of support, but they encourage me to do things for myself and I am able to go into town and do some shopping". A relative commented, "They encourage [my relative] to do things for [themselves]. [They] do their own washing and cooking. Staff treat [them] as an equal and so [they] feel really comfortable with them". These close relationships were clearly in evidence throughout both our inspection visits.

Requires Improvement

Is the service responsive?

Our findings

Staff knew the people they were supporting and caring for well and people told us they had confidence that their needs would be met. One person explained, "I feel where there is a genuine need, things will be addressed". People were positive about the way staff provided care and support with one person saying, "We are well looked after. We trust the staff to do their best for us". Another person said, "Overall the home is very accommodating and helpful in lots of ways". Many people commented positively on how staff at the service help them maintain their independence and promote links with the local community. We observed people coming and going to various activities and appointments.

Some people expressed a concern about how the service supports people with more complex needs or whose needs increase over time. One person commented, "For anyone with independence, this is a good place to be. From what I see I'm not so sure it is ideal if you have other needs". Other people made similar comments and we found that the service struggled to meet the specific needs of people with increasing health concerns. The service's own Statement of Purpose, which is a document which sets out the way the service intends to operate, stated that the service 'is intended to be both flexible and responsive to the individual's changing needs'. We found that the service was not able to operate in this way and the manager confirmed that staffing levels meant that once people required a particular number of care and support hours each week they were not able to meet their needs and would look to support people to move people on to other services.

Initial assessments of people's needs were carried out to ensure that the service could meet people's needs when they first moved in. Both the registered manager and a visiting health and social care professional confirmed to us that these assessments include, as far as possible, a prediction of future needs given the service's limitations with regard to people's deteriorating health and complex conditions.

The initial assessments formed the basis of the care plan and contained information to guide staff, although this was not always sufficiently detailed, especially for any agency staff and those new to care. Care plans were kept in people's flats and had been shared with relatives, where appropriate. Daily notes were an effective way of recording current concerns and issues and staff were signposted to any new information in the notes when they attended handover meetings. A communication board in the staff room also highlighted important information for staff to be aware of and we observed staff checking this before they started their shift.

The care and support people received was subject to ongoing review. Most of the care plans we viewed had been appropriately updated, although some were due for review. For example, one person's moving and handling plan was completed in June 2015 and stated it was to be reviewed every three months but had not been reviewed since. The information in the plan was also very basic and simply stated for staff to 'follow all training for moving and handling at all times' and did not give any individualised guidance.

We saw evidence in some people's records of individualised care which responded quickly to people's changing needs. One person had developed a pressure sore and bedrails had been fitted to their bed to help

keep them safe whilst they were getting better. We saw that these were removed as soon as the person had made a full recovery. We noted that one person's morning call had been set at 6.15am at their request. Equipment, such as moving and handling equipment, was obtained for people when they required it and the service worked in partnership with other agencies to help meet people's needs.

Although we only regulate the delivery of personal care at a service such as this we were impressed by the provision of activities and meaningful occupation for people. All the people we spoke with commended this provision and praised the activities co-ordinator. People felt it was a great asset to have such a service in an extra care housing service. One person said, "Being able to take part in things gives me so much enjoyment and without them I would be bored and less happy". Another person told us, "The activities going on make the difference between boredom and feeling positive. They lift your spirits". A relative remarked, "Without the stimulation these activities provide I do feel [my relative's] health would go downhill". We saw that the commitment to provide occupation and activity to people made a significant difference to people's wellbeing and to their self-esteem and felt it worthy of documenting in this report, even though it stands outside of our remit.

The provider sent out questionnaires and held regular meeting with people who used the service in order to get feedback and invite them to share their ideas for any improvements the service could make. Minutes of meetings were handed out to all tenants, including those who did not attend the meeting and all the people we spoke with found them valuable and positive. One person commented, "We have questionnaires and residents' meetings. In general they take notice of what we feel. At one meeting we said agency staff should knock on doors before entering and now that happens". Another person told us, "We have residents' meetings and all suggestions are listened to and, where possible, put right".

We saw that the service had a complaints policy and people told us they knew how to make a complaint if they needed to. The provider told us they had received no formal complaints in the last year. Compliments and informal complaints were logged and we saw that four informal complaints had been logged. One minor issue had been resolved but the other minor issue had no action documented. Two more substantial issues had been investigated and staff involved had been spoken with as part of the investigation and appropriate action taken. Recording procedures in relation to complaints were not robust and made it difficult to track the informal complaints.

Requires Improvement

Is the service well-led?

Our findings

People who used the service were not clear about who was managing the service but were positive about the 'office staff'. One person told us, "I don't know who is in charge here". Another person said, "I have no idea who the manager is". A relative said, "The office staff are the ones I come into contact with and they are always helpful" and this was the opinion of all of the people we spoke with.

The manager in day to day charge had been temporarily promoted two years ago to this role from being a senior carer and had appropriate leadership qualifications. The registered manager was at the service approximately once a week or less. The manager in day to day charge communicated well with the registered manager but structured support for them had been difficult in recent months. The registered manager told us they had been concentrating their time at another service. The manager in day to day charge was not clear about their future in the role and the expectations of the organisation and this lack of clarity and support for them had the potential to impact on morale – both of this manager and of the staff team as a whole. They told us they often cover parts of shifts and we noted that they carried out many duties of a full time manager whilst they were actually only part time. One member of staff commented, "We have lost [the manager in day to day charge] from the shop floor. They are very supportive and [do] their best but it works better with a more consistent manager".

Staff told us they felt well supported and that they could approach the management of the service if they needed to. Staff meetings were held regularly and gave staff the chance to raise issues. One staff member told us, "I have found the staff meetings helpful. Staff can raise an issue there or go to a senior".

We saw that the registered manager demonstrated an understanding of her role and responsibilities. She understood the requirement to submit notifications to CQC but we did also discuss issues which it would have been appropriate to report to both CQC and the local authority safeguarding team. Part of the reason for failing to notify us appropriately was due to a misunderstanding of who could send in a notification to us. We clarified this point and confirmed that the manager in day to day charge could undertake this task.

The manager received their own support and was able to update their knowledge and skills as part of Orbit's regional management team. The registered manager's line manager was seen by the manager, and by the staff at the service, as a supportive and approachable person who visited the service on a regular basis.

The manager was clear about the challenges that faced the service and knew the areas which were a cause for concern. They had already begun to look at having a different pharmacy supply the medicines used at the service as they felt this might reduce errors and would give staff additional support and guidance. They shared with us that they felt the most acute issue they had faced had been a shortage of staff but they were hopeful that things were beginning to improve and staff vacancies had decreased significantly. There had also been occasions where the registered manager appeared to have been unable to successfully address issues of staffing levels and management support for the service with senior staff at Orbit.

We found that record keeping across the service could be improved. Some records were not complete,

including induction records for new staff. Some care plans required updating and additional information to guide staff, especially those relating to people's health conditions. Records we requested were produced quickly and most were well organised. Records relating to medicines required attention in some areas and we discussed this with the manager.

There was a system of audits in place but we found that there were occasions when it was not effective. The medicines audit had been delegated to a member of staff but the audits we saw had not identified any of the issues we found. However other areas of concern had been identified, such as the lack of opening dates on topical creams. We noted that incidents of this happening had reduced greatly over a two month period and we found no issues during our inspection.

A monthly general audit was carried out by the manager in day to day charge. This covered frequency of supervisions, care plans, reviews, tenant meetings, slips/trips and falls, incidents of violence, staff issues and medication errors. This audit was carried out by the manager in day to day charge who shared the findings with the registered manager. The audits picked up small as well as significant issues. For example it had been identified that one person could not hear the intercom and action was taken to address this. Falls were monitored and action taken to try and reduce the risk of falls, for example one person's furniture had been rearranged with their permission.

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 The provider failed to assess all risks to health and safety and failed to manage medicines safely. Regulation 12 (1) (2) (a) and (g).

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff. Regulation 18 (1).