Understanding Care (Warwickshire) Limited

Unique Senior Care

Inspection report

The Care Office, Queensway Court
Queensway
Leamington Spa
Warwickshire
CV31 3JZ

Tel: 01926839555
Website: www.homeinstead.co.uk/warwickshire

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23 November 2017

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
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

The inspection took place on 7 November 2017 and 23 November 2017. Both inspection visits were announced.

This was the first inspection of this service following its registration with us in November 2016.

Home Instead Senior Care – Queensway Court is registered to provide personal care to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is rented or purchased on a shared ownership scheme, and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection only looked at people's personal care service.

Queensway Court has 178 apartments consisting of one and two bed apartments. People living at Queensway Court share on site facilities such as a lift, lounge, restaurant, laundry, garden, activities room, café, a hairdressing salon and a bar.

At the time of this inspection visit, Home Instead Senior Care Queensway Court supported 57 people in 57 apartments. Home Instead Senior Care Queensway Court also provides an on call emergency service to everyone living in the building, not just those people who they provide personal care to.

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

There were enough staff to provide the care and support people required, however people and relatives told us call times varied which impacted on their routines. People told us staff were friendly and caring, but continuity of care staff was not always supported. However, people said in the last couple of weeks, continuity had begun to improve.

People's opinions of the service were mixed, with some people describing differences in how staff supported them in a way that was personalised and responsive to them. Some people experienced staff that arrived around the time expected and stayed long enough to provide their care. Other people felt staff were rushed and care call timings were not always known in advance, or provided at times they preferred.

Staff received an induction when they started working for the service and had their training updated to support them in meeting people's needs effectively.

People felt safe using the service and there were processes to minimise risks to people's safety. These

included procedures to manage risks identified with people's care. Staff understood how to protect people from abuse and the action to take, to safeguard vulnerable people.

People were administered medicines by staff who were trained and assessed as competent to give medicines safely. However, we found patch medicines were not always given as prescribed and in line with manufacturer's guidelines. Recent medicine policy changes had not been followed consistently and records showed staff's knowledge of how and what medicines should be recorded, needed more to time to embed to be effective.

The provider conducted pre-employment checks prior to staff starting work, to ensure their suitability to support people who used the service.

The management and staff followed the principles of the Mental Capacity Act (MCA). Staff respected decisions people made about their care and gained people's consent before they provided personal care.

Care plans required improvement and needed to be more detailed so staff had sufficient information about people's care needs and instructions of what they needed to do on each care visit.

Staff supported people to attend activities provided within the extra care housing complex

People at Home Instead Senior Care Queensway Court were able to access in-house healthcare professionals when required. This included two in-house nurses, five days a week who could respond to changing health needs and seek appropriate interventions. They were also supported to access GP's and hospital services if needed to maintain their health.

Staff felt supported to do their work effectively and said the managers were approachable and available.

People and relatives had mixed views in how management dealt with concerns brought to their attention. Some people felt they could raise concerns with the management team, knowing they would be listened to, while others had raised issues with limited improvement and consistency. However, it was clear some people did not feel comfortable raising their concerns in face to face interviews.

The provider's quality monitoring systems included asking people for their views about the quality of the service. However, it was clear some people did not feel comfortable raising their concerns in face to face interviews. The provider did not hold meetings with people and or relatives separately, away from those organised by the housing company that looked at all issues within the building, not just those focussed on care delivery. The provider agreed to consider this so they had a way to capture people and families feedback.

The management team checked people received the care they needed by observing staff during visits and through feedback from people and staff.

There was a programme of other checks and audits which the provider used to monitor and improve the service. We found these were not always implemented consistently or were sufficiently robust to ensure people always received care and support that met their needs and expectations.

At the time of this inspection visit the location name was Home Instead Senior Care Queensway Court. Following this inspection visit, on 30 November 2017 the provider told us verbally they were no longer part of the Home Instead Brand. As of 4 December 2017, the location name would be Unique Senior Care and the

regulated activity of personal care would still be provided but under this name. They informed us they had notified our contact centre to ensure their registration with us was correct.

The registered manager had not submitted statutory notifications to us in accordance with their legal responsibility to do so. They gave us assurances in future; they would send us relevant statutory notifications for incidents or important events.

We found a breach of the Health and Social Care Act 2008 (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People felt safe living in their own apartment supported by enough staff who provided their care and support. Staff understood their responsibilities to report any concerns about people's safety or if they believed people were at risk of abuse. The manager analysed falls records to identify any patterns or trends which resulted in minimising the risks of issues re-occurring.

Is the service effective?

Good

The service was effective.

Staff were skilled and trained to meet people's needs effectively. Staff understood their responsibilities in relation to the Mental Capacity Act 2005 and supported people to make their own decisions. People were supported to maintain their health and staff involved other health professionals in people's care when needed. Links with local Clinical Commissioning Groups saw community nurses on site to assess and respond to people's changing needs and emergencies, limiting further interventions or hospital visits.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's care was not always provided in line with their individual routines and preferences. People were not always comfortable in voicing their concerns and in some instances, felt action was not taken. Staff knew people well and understood their likes, dislikes and preferences for how they wanted to be cared for and supported. People and relatives told us staff were caring and respected their privacy and promoted their dignity and independence.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care calls were not always provided in line with their preferences which impacted on some people's preferred routines. People were not always confident that complaints or concerns would be dealt with promptly and that improvements would be sustained.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The providers were keen to deliver a service that supported their ethos and passions for providing good care. However, we found their audit and governance systems were not thorough to sustain and drive improvements. We found statutory notifications for safeguarding incidents and serious injuries had not been sent to us, which is their legal responsibility to do. Quality assurance visits with people and complaints did not always identify and improve the delivery of service for some people.

Unique Senior Care

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 checked 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.

Inspection activity started on 2 November 2017 when we spoke on the telephone with eight people and three relatives of people who used the service. These telephone interviews were completed by an expert by experience. An expert by experience is someone who has experience of using this type of service. People and relatives had consented to speaking with us. Following the first inspection visit to the provider's office, we spoke with one person and a relative of another person who received personal care.

We visited the office location on 7 November 2017 to see the registered manager and office staff; and to review care records and policies and procedures. This visit was announced and completed by one inspector. We gave notice we would return on 23 November 2017 to speak with the registered manager and staff who supported people with their care. This second visit was completed by two inspectors.

We asked the local authority if they had any information to share with us about the service delivered by the provider. They visited this service in September 2017 and they shared their findings with us. Local authorities are responsible for monitoring the quality and funding for people who use the service. We looked at the information we held about the service and the provider. Prior to this inspection, we had received information that suggested some people were not always satisfied with the quality of care provided to them. We looked at this during our inspection visit. We looked at statutory notifications the provider had sent us. Statutory notifications are reports the provider is required by law to send us, to inform us about incidents that have happened at the service, such as an accident or a serious injury. We found not all statutory notifications had been sent to us.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We found the PIR was a reflection of what we found during our visits.

During the inspection visit on 7 November 2017, the provider arranged for us to meet with representatives from external organisations. We met the extra care housing manager responsible for the premises at Queensway Court and the commissioning manager, who commissioned support at the service on behalf of the local authority. We also spoke with a visiting relative and a healthcare professional who supported people who received care from the service.

At the inspection visit at the provider's office, we spoke with the manager, the registered manager, both owners of the agency (in the report we refer to them as the provider), a director of people, a learning and development manager and a team leader. We spoke with two care staff and two team leaders who both provided care to people (In the report we refer to them as staff).

We reviewed care plans for three people including their daily records to see how their care and support was planned and delivered. We looked at other records related to people's care and how the service operated. These included the staff duty rotas and details of calls, medicine records, complaints, staff training records and the service's quality records. Quality records included audits and notes of meetings with staff.

Good

Is the service safe?

Our findings

People told us they felt safe with staff who provided their care and support. When asked what made them feel safe, one person told us, "I do feel safe, because it's knowing that if anything happens at all, I just have to press my buzzer and somebody will be here to help me. If I was concerned about anything the carers are doing, I would go down to the office and speak to [manager's name]." A visiting relative felt their family member was safe. They said, "Staff are always on site, it's great and they greet [person] with a smile." Another person said staff usually let themselves in using a 'key safe'. They said, "Although it's not a very big flat, they will always ring the bell before they unlock the door and will always call out their name so I don't panic about who is coming in."

People had mixed views to whether there was enough staff to meet their needs. A number of people told us there were not enough staff, however those people said they did receive a care call and care calls were not missed. Because some of their calls were not always at a time they preferred, they believed this was because of a shortage of staff. They knew if they needed extra support this could be arranged by speaking with the manager so that an appropriate assessment of need could be carried out. Staff told us the staffing arrangements were sufficient for them to spend the time they needed with people. A team leader showed us their call scheduling system and they said at times, staffing levels meant some future care calls were not always planned in advance, however the calls were covered.

The provider protected people from the risk of harm and abuse. Staff had received training to protect people from abuse and understood their responsibilities to report any concerns. There were policies and procedures for staff to follow should they have any concerns that abuse had happened. One staff member explained what they would do if they saw an incident of abuse. They said, "If I saw anything, I'd remove the member of staff, call for the manager. I would have to deal with it and report it to the safeguarding team." Records showed the provider managed safeguarding incidents according to their policies and procedures which helped to keep people safe, However, they had not always notified us of incidents of abuse in accordance with their legal responsibilities. They assured us in future, all allegations of potential abuse would be reported to us without delay.

The provider had taken action to minimise people's individual risks. Where risks to people's individual health or wellbeing were identified, their care plans described the actions staff should take to minimise them. Risks to people's mobility, nutrition and communication were assessed and staff were given guidance on managing the risks to ensure the best outcome for the person. For example, for one person who was not able to mobilise independently, their care plan explained the number of staff and the type of equipment staff should use to support them to move. Records showed staff had received training in moving and handling, so they could support people to move safely. People's care plans were regularly reviewed to make sure any changes in their needs and abilities were known and planned for.

The provider had taken action to minimise risks related to medicines administration and management. Medicines were managed and administered safely, in accordance with best practice guidance. Staff were trained in medicines administration, which was updated in line with changes in policy and practice. For

people who had the capacity to manage their own medicines, staff were advised which medicines the person had been prescribed, because this was related to information about their medical condition. Staff recorded when they administered a person's medicines such as topical creams or if they administered eye drops. Most people self-medicated so there was no requirement for staff to complete medicine records. For people who received patch medicines, records showed these were not always given as prescribed. For example, one patch medicine was recorded as being applied one day earlier than it should have been, and on another occasion, one day after it should have been applied. Patch records did not record where people should have their patch applied which could cause possible skin irritation or overdose.

The provider had taken action to minimise risks related to emergencies and unexpected events. People's individual risk assessments included an assessment of risks related to their own homes, such as trip hazards and other environmental risks.

Staff told us they received training in infection control and food hygiene. Staff felt confident they knew how to reduce risks of cross infection and how to ensure meals were cooked and safe to eat. One relative told us about an issue where they felt staff did not thoroughly clean after personal care was carried out but said this had recently improved.

Records showed staff received training in subjects such as basic life support and fire training; to give them the skills they needed to respond safely to emergency situations. People who needed emergency assistance activated a call pendant and staff attended to ensure people were safe. People told us this service made them feel safe, 'knowing someone is around to help if needed'.

The manager analysed falls and any damage to people's skin, to ensure appropriate action was taken to minimise the risks of a reoccurrence. Their analysis demonstrated that healthcare professionals were asked to support people when risks to their skin were identified. The manager's analysis showed falls were related to people's individual needs and abilities. The manager told us they planned to extend their analysis to include 'incidents', that is, unplanned events that brought risks to people's health or wellbeing. They told us their analysis would identify any trends or patterns that might require changes to their policy or procedures.

We took confidence from the commissioner's recent inspection, that staff were recruited safely. The commissioners had reviewed staff recruitment files and found the provider made all the checks prescribed in the regulations to make sure staff were suitable to deliver a personal care service.

Good

Is the service effective?

Our findings

People received care from staff who had the skills and knowledge to meet their needs effectively. Records showed staff received training in essential subjects, such as, moving and handling, food hygiene, first aid and safeguarding during their induction to working for the service. Staff also received training in subjects that were relevant to people's individual needs, such as Alzheimer's and other types of dementia, and catheter care. We spoke with staff relatively new to the service. They explained their induction supported them to learn at a pace they preferred and enabled them to get to know the people they supported. One staff member said, "I had some shadowing all day that went well, I just watched. Then when I was more comfortable, I joined in."

The learning and development manager told us the provider's induction linked in with the Care Certificate. The Care Certificate assesses staff against a specific set of standards. Staff need to demonstrate they have the skills, knowledge and behaviours in providing compassionate and high quality care and support. Another staff member who was experienced in working in care said, "I did three solid days – it was quite intense even for me as an experienced staff member." They said their training at this service was, "The best training programme I have been on." One staff member said they found dementia training useful because it gave them information about the different types of dementia and how this affected the person living with dementia.

Prior to this inspection visit we received some concerns that suggested staff were not familiar with safe moving and handling techniques. We saw a complaint had been made and responded to by the provider earlier this year because of a moving and handling incident when a person was not appropriately positioned in the sling when being hoisted. We looked at the provider's findings and their response showed a staff member received extra shadowing support from senior staff to ensure people were always transferred safely and effectively. Staff we spoke with said they felt confident in their moving and handling practice and when supporting people with hoisting.

Records showed staff attended team meetings to share information. They discussed any changes to people's needs, and any new equipment that had been prescribed or requested. Staff were reminded of their responsibilities and the provider's expectations of how they delivered the service and encouraged to study for nationally recognised qualifications. Staff said supervisions formed part of their reflective practice and 'on the spot' checks were also included as part of their observations and supervisions. Staff told us they felt supported by their manager who was approachable and supported them in a way that helped them to remain effective in their role. For example, if additional training or shadowing was needed, this was provided.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best

interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The local authority has responsibility for making these applications but the provider has a duty to alert the local authority of any restrictions so applications can be made. At the time of our inspection visit there were no restrictions on people's liberty.

Staff worked within the principles of the MCA. They gave people choices and respected the decisions they made. One member of staff explained, "We ask for their preference…they have a choice." They said they respected people's choices, "We guide them, suggest to them." For some people whose communication was limited, the staff member said a person would, "Shake their head." Staff said if people could not make a decision, they asked other care staff or referred to the care plan.

People were supported to maintain a balanced diet that met their needs and preferences. Where people needed support with preparing and eating meals, their care plans included their likes, dislikes and any allergies that might include restrictions to their diet. Staff said they usually prepared meals such as sandwiches or microwave meals.

People were supported to maintain their health and were referred to other healthcare professionals, such as GPs and dentists, when needed. One person was pleased with the help they received from staff, "I am diabetic, and my carer came in the other morning and said that she didn't like the look of me at all, so she called my GP to arrange for the nurse to come and check me over."

People's medical histories were included in their care plans, which supported staff to recognise the signs of an episode of ill health. We spoke with a visiting healthcare professional who told us about a new initiative at the service where two nurses will be based on site five days a week to help reduce unplanned hospital admissions and GP referrals. They said, "We are working collaboratively with other health professionals and services, looking at falls management, fall risks and those at high risk." They added, "The purpose is to improve quality care and minimise health interventions." They told us they gave the manager a guide for staff to follow, called 'Stop and think'. It provided staff with information to 'recognise what is not normal'. Meetings and reviews of the project were planned to assess the impact on people and the service, looking at admissions, the root cause of the referral and how this had benefitted those at the service.

Requires Improvement

Is the service caring?

Our findings

People were supported by kind and caring staff. In a provider's recent internal quality assurance survey some people had commented, "I love the carers and the care" and, "I get on very well with [Staff name]." Where providers have themselves collected people's feedback, their own surveys showed people had high levels of satisfaction with the service provided. Everyone who answered said that staff were caring, friendly and respectful, and that office staff were courteous.

People told us when staff spent time supporting them, staff were kind and considerate. Comments included, "If I'm being fair, most of them seem to be here for the right reasons and take their time to help in the way that I need to be helped." "If I'm having one of those mornings where it is particularly difficult for me to do anything, then I can get a bit tearful and usually the carers will find me a tissue and at least sit with me for a minute until I tell them that I'm really alright and they must get on."

Staff told us they had a caring philosophy. One staff member said, "I am compassionate, I try to understand and I never leave the person without anything they need." This staff member said part of their induction included the providers explaining their philosophy of care and the standards of care they wanted people to receive. The staff member explained they had 'spot checks' that looked at "How we communicate and how we recognise people who need help."

The provider arranged workshops for staff to develop their understanding of key concepts of care, such as 'Driving dignity and respect' and 'Promoting independence in older people'. Staff told us they wanted to promote independence as this was integral to supporting the ethos and values of living within an extra care housing scheme. One staff member said it was important for people to do as much for themselves as possible. One person confirmed that staff promoted their independence. They said, "They (staff) respect my privacy; they say if you can manage it yourself, do it….I want to prove to myself I can do it and they help me with that."

People's care plans included information about their likes, dislikes and preferences for care and support. People were able to specify the gender of the staff that supported them with personal care. People who received personal care told us they felt comfortable with staff and for the majority of the time, received care from staff of the gender they preferred. However, they appreciated that at night or in an emergency there could be occasions when they may not receive support from staff of a gender they preferred. For some people, this had caused them concern. A person shared their experiences with us. They explained, "I was certainly asked what time I would like the calls to happen and also which days of the week I wanted my shower originally and I also told them that I didn't really want a male carer at all, which they said was not a problem. However, I need a night time call to change my continence pad and sometimes there is only a male carer on overnight and I'm afraid when that happens, I tell him just to go away and I will manage until the morning carers come on."

Whilst the majority of people found staff helpful, kind and considerate, other people told us about specific examples that disappointed them. One person said, "I think overall, probably 90% of the carers have the

right attitude, there are just one or two who just seem to come in, rush around, do things as quickly as they can and then get out of here without even having the decency to just have a chat or ask how I am. Those mornings do feel a bit stressful compared to the others." Another person told us about how some staff did small things that made a difference to them, but said, "Yet there are one or two that I don't think it would even enter their heads to think about it, so I end up always having to say something."

We found the provider's approach to how they supported people was not always caring, or centred around people's individual needs and routines. For example, in the provider's survey some people had commented, "My morning call has been too early." The manager told us, "We struggle to give everyone their preferred time. We ask, and say if we don't have that time slot." Most of the people and relatives we spoke with said care times were centred around the call rota, instead of what they wanted. One person told us their personal routine, especially on a weekend was affected because their care call was not always provided when they wanted it.

We found most of the people who shared their concerns with us were worried about sharing them with the management and provider. One person said, "If you mention something you're not happy with, [manager] makes me feel guilty for opening my mouth so I'm afraid of late I just haven't bothered to mention anything at all."

Reviews of care took place at six monthly intervals or when people's needs changed. Regular quality assurance visits were carried out by senior staff who discussed people's care with them and what they thought of the service. Most of the comments we saw were positive. However from speaking with people, they told us they were not always involved in ensuring the service met their needs.

People's care plans included important information about the person such as their background, past and present. Staff said this helped them to understand the person's life history and what they enjoyed doing and what was important to them. One person we spoke with said, "I was down in the dumps – staff cheered me up a lot. They talk to you, some don't acknowledge you, these guys do." They also said, "Staff are very good and smiley."

Requires Improvement

Is the service responsive?

Our findings

People gave us mixed feedback when we asked them if the service they received was centred on their needs and preferred routines. Almost everyone we spoke with said they wanted a copy of the call rota so they knew when their care calls were arranged and who was delivering their care. The senior staff member responsible for shift and rota allocations said at times it was difficult to issue a rota. This was because they could not always be completed with the name of the staff member who was going to be responsible for a person's care delivery on every day. Rather than issue an incomplete rota, a rota was only sent out to people if they had specifically requested it. People told us the issuing of rotas had improved in the weeks prior to our inspection visit.

We found examples where the timing of care calls impacted on people's preferred routines. For example, one person wanted to watch a particular television programme which was important to them. However, the timing of their care calls meant they were put to bed, and missed their favourite programme. The person told us they had raised this with the provider and records confirmed this. Rather than reschedule this person's care call, a senior staff member had suggested they get a television for their bedroom. We asked the manager if this was a good solution. They responded, "If everyone wants a call at the same time, we can't do it…it means someone else doesn't get theirs." They agreed this was not person centred care.

Some people shared their concerns about the continuity of staff and if staff were responsive to their individual needs. Comments included, "Everything is written in my care plan, but to be honest, the carers never really have time to look at it, to understand what my likes and preferences are all about. The ones who come to me more regularly than the others, I think they understand me well, but the ones I only see occasionally really don't know me from anybody else in the flats to be honest. Sometimes, I will see a carer and then I won't see them again for several days so it is really difficult for them to remember much about me at all." A relative also shared concerns in how the call timings affected their family member. They said, "I have raised concerns about the timings of the visits to [relative]. My main concern has been that when they are running really late, [relative] will usually dress herself because she wants to go down to one of the activities, and it means then she misses out on her shower. If they were to come on time, she would have plenty of time to have a shower, get dressed and have something to eat before needing to be downstairs. Sadly, when I explained this to the office, they told me the timings are out of their control and that I will just have to tell [relative] not to dress herself before the carers get there. I didn't really think that was a satisfactory response, but there is little I can do to change that."

We shared these concerns with the registered manager. They told us, "We have struggled to arrange call times for people. Staff have shifts and we have to fill them. For us to give everyone a 08:00am call, we struggle."

People shared concerns about the continuity of care staff. People and relatives said that some care calls were consistent, others were not. In response, the registered manager said, "Tea and evening calls – definitely we struggle to get continuity." Where people shared their concerns directly with us, we found people and relatives were not confident they would be listened to, or that action would be taken. One

relative told us about their concerns with staff times, continuity and staff not staying for the required time. They said that having raised concerns on a number of occasions, they had doubts improvements would be sustained. Prior to our inspection visit the provider had an announced two day quality visit by the local authority commissioners in September 2017. This visit identified common themes regarding call times, continuity of care staff and a lack of sustained improvement that caused people concern, which some people shared with us during our inspection.

Records showed 22 complaints had been made since January 2017. The registered manager said complaints were, "Usually responded to within 48 hours and we say if we need longer." Some of the complaints the provider had received had similar themes to the issues we found. For example, on 30 August 2017 a complaint had been made about inconsistent care staff. This complaint was investigated on 31 August 2017 and sent to the provider for a formal response. The formal complaint response letter was not sent to the person until 31 October 2017 and the provider did not tell us the reason for the delay. This meant the provider had not acted within the timescales set out in their own complaints procedure.

People were supported to maintain their interests and preferred pastimes and were supported to engage in activity and socialising. People were encouraged to attend events and talks organised by the housing provider in a communal room at the housing complex. Records showed that external speakers, such as a community policeman and a local fire prevention officer, were invited to share their professional knowledge with people to support them to stay safe.

Care staff supported people to attend the events that were organised within the housing complex, such as talks, bingo and religious services. People were able to book staff time in advance to support them to and from their homes to attend their chosen events.

Photographic records showed people were supported to engage in community activities and to maintain their interests. Photographs showed, for example, people were supported to go and watch a football match, to enjoy a picnic in the park and to attend coffee mornings and cake sales that were organised within the housing complex.

Requires Improvement

Is the service well-led?

Our findings

Before our office inspection, we spoke with people who used the service and relatives of those who received a service. Feedback people gave us was mixed. People were complimentary of the staff, but said the service and call times were not always flexible and responsive to their individual and preferred needs. One relative told us, "We fit in with the rota (staff), not the other way around."

At our inspection visit, we discussed this with the provider, registered manager and manager. The registered manager said, "We struggle to give everyone their preferred time. We ask and say if we don't have that time slot." The manager said, "If we give someone their preferred time call that means someone else will not get theirs." We shared people's concerns with the provider and found this was a common theme. For example, a quality assurance visit completed in September 2017 by the local authority echoed similar concerns. We found from speaking with the team leader who completed call schedules, people's preferred call times were 'difficult to achieve'. A number of people told us they wanted to know who was going to be providing their care but they did not always have advanced notice of who was supporting them.

We asked how 'people's voice' was sought. The manager said they had just completed a quality audit in October 2017 which showed out of 40 comments, 14 were negative. Some of these negative comments included, "I want regular carers and rotas, carers don't always stay as long as they should, I want the same carer for a.m. and p.m." The provider recognised this was an area for improvement and the manager had created an action plan to address these concerns. Where improvements were needed regarding call times, the action plan said it was for the 'clients to discuss with their keyworkers' rather than for the provider to check with people. This put the onus back on people to report concerns, rather than proactive management from the provider. However, speaking with a relative and a person after our inspection visit, they said continuity of staff and being issued with a rota had started to improve.

People attended regular meetings arranged by the housing manager; however these meetings included all tenants, even those who did not receive personal care. 'Resident' meetings of 16 February 2017 and 27 October 2017 did not include any discussion of issues related to the personal care service. The provider said there were no meetings specifically for those people they supported. This meant people did not have regular opportunities to share their concerns with the provider. We discussed the potential to have a sub group meeting, just for those who received care so to distinguish between tenancy issues and service user issues. The provider agreed to consider this. We suggested this because the provider did not have their own meeting to discuss with people they supported, what their concerns were.

The manager and registered manager said quality assurance visits were completed, and we saw examples where people were asked what they thought. However, people who shared their concerns with us did not always want their identity to be known. We therefore raised these concerns anonymously with the provider who assured us they would address these issues.

People and relatives told us if they raised concerns or complaints, action was not always taken and similar issues remained unresolved. For example, a relative told us about how staff completed personal care

routines that did not always promote the person's health and wellbeing. A staff member told us they were aware of how a person's cream was not applied in the way the person preferred, but said this had now been improved. We found written complaints were dealt with, but a relative said that if poor practice was seen, 'the staff member was stopped from the call'. We saw two complaints where a staff member was stopped from a person's call, yet nothing was recorded to show what measures were taken to improve the staff member's practice to prevent something similar happening again.

The provider had a system of audits and checks, however some of these required improvements. For example, Home Instead (national provider) changed their medicines policy which meant staff now had to record medicines that had previously not been recorded. The manager said staff had read and understood the policy, however MAR records indicated staff's knowledge was not consistently applied. We asked if checks had been put in place to check staff's knowledge and practice. We were told the next audit was not until six weeks after the introduction of the new policy which was at the end November 2017. Staff's understanding and practice immediately after the implementation of the policy had not been checked. We found patch medicines and creams were not correctly recorded in line with policy changes. One person's medicines did not match care plan information, even though care plans had been reviewed after the medicines policy had changed. This made it difficult to understand which medicines the person was required to take now and which medicines could require staff assistance.

Care plan audits were completed but examples we saw still required attention to ensure staff had the information they needed to support people. For example, one care plan had not been reviewed since October 2016, although quality assurance visits had taken place. There was insufficient information regarding personal history. There was no evidence of referral to memory support and when staff identified issues for the person, there were no offered solutions. Care plans did not always describe the support people needed on each care call. However, a newer care plan recorded what was required at each care call, but this demonstrated inconsistency in how care plans were completed and audited.

The manager proactively completed an analysis of falls each month to ensure people received the right support to limit potential for further falls. However, there was no regular analysis of any other accidents and incidents reported by staff. The manager told us they took it upon themselves to do fall analysis and agreed to use the same system to monitor accidents and incidents. This would ensure any patterns or trends could be identified and action taken.

There was a registered manager in post which is a legal requirement. When we returned on 30 November 2017 to provide written feedback, one of the providers told us as of 4 December 2017 they were no longer trading as Home Instead Senior Care Queensway Court. The new name would be Unique Senior Care and the regulated activity of personal care would still be provided but under this name. They informed us they had notified our contact centre to ensure their registration with us was correct.

However we found the provider did not always follow their regulatory responsibilities. We found the provider had not sent us statutory notifications for important and serious incidents. At our inspection visit we identified two safeguarding incidents and two serious injuries that we had not received statutory notifications for, which is the provider's legal responsibility to do. When we described these to the registered manager and manager, they said, "We did not know they had to be sent to you." Failures to notify us of serious injuries and safeguarding incidents had prevented us from monitoring the service effectively.

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

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered persons failed to notify the Commission without delay of important or serious incidents which was their legal responsibility to do so. Regulation 18(1)(2)(a)(b)(e)