Destiny Nursing & Care Agency Ltd

Berkeley house

Inspection report

Berkeley House
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Edgware
Middlesex
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Tel: 07950461139

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an announced inspection that took place on 28 September 2016. It was the first inspection of this agency at this location, after the agency had moved addresses locally.

Berkeley House is a homecare agency based in Barnet that provides services to people of any age, including those with dementia, mental health needs, or physical disabilities. At the time of this announced inspection, they were providing personal care and support to 14 people living in their own homes.

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.

Representatives of people using the service, and most community healthcare professionals, provided good feedback about the service and its impact on people's quality of life. Staff were described as caring, careful and knowledgeable. People usually received the same staff, which helped positive relationships to develop. We found that the service was caring and responsive.

However, we found some significant concerns about how the service was operated that particularly undermined people's ongoing safety. Risk management processes were not comprehensive. They did not ensure that all reasonable actions were taken to minimise risks to people using the service, including in relation to medicines management, checking for a safe care environment, and supporting to move people safely. Whilst efforts were made to address people's needs in practice, people's care plans did not consistently address all their support needs and sometimes were not set up by the agency. This all had potential to undermine safe care practices.

The provider failed to promptly notify us of significant injuries to two people whilst receiving care from the service, which prevented us from monitoring the service effectively. One of these injuries resulted in hospital admission.

Criminal record checks and appropriate references were not in place for some newer staff before they started working in people's homes, which did not ensure people's safety.

There were few recorded governance systems in place, and so we identified shortfalls that the management team and the provider had not recognised or addressed.

However, the service worked well in partnership with other agencies, and provided staff with a positive and supportive culture, to help ensure people received good care. The service provided good support for people's health, nutritional and end-of-life needs. We found instances where the service had taken practical action to protect people. Attention was also paid to upholding good standards of infection control.

There were overall three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report. However, full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Despite good feedback from people's representatives about careful staff, two people experienced accidents when receiving care from the agency, one of which resulted in hospital admission. Risk assessment and care planning processes were inadequate at showing that action was being taken to identify and address safety risks. This included for risks relating to supporting people to move, skin care, medicines management and the physical environment.

The service was not always undertaking timely recruitment checks to ensure people using services were supplied with safe and suitable staff. We found instances where new staff were providing care to people before reference checks of their previous employments and criminal record checks were completed.

However, we found instances where the service had taken practical action to protect people. Attention was also paid to upholding good standards of infection control.

Is the service effective?

Requires Improvement

The service was not consistently effective. Where people lacked capacity to consent to the care services, the service had not documented a capacity assessment and, if necessary, followed a best interests process, in line with principles of The Mental Capacity Act 2005.

However, the service was effective at improving the quality of people's lives. The agency provided people with good healthcare and nutritional support and liaised well with community healthcare professionals. The staff supplied to provide care to people had adequate skills for their roles and responsibilities.

Is the service caring?

Good

The service was caring. People's representatives commented positively about the agency's staff. Staff spoke about people and the support they provided in an appropriate manner. The service provided good end-of-life care.

The same staff usually attended to people, which helped positive and trusting relationships to develop.

Is the service responsive?

Good

The service was responsive. Stakeholders' experiences and concerns were listened to and learnt. Feedback from people's representatives indicated responsive care was being provided in practice. Care plans partially reflected this.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. Quality auditing systems were not effective at identifying and addressing risks to the safety and welfare of people using the service including those we identified during this inspection. Records relating to people using the service were not accurately maintained.

The provider failed to promptly notify us of significant injuries to two people whilst receiving care from the service, which prevented us from monitoring the service effectively.

However, the service worked well in partnership with other agencies, and provided staff with a positive and supportive culture, to help ensure people received good care.

Berkeley 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.

This was an announced inspection that took place on 28 September 2016. 48 hours' notice of the inspection was given because the service is a domiciliary care agency and the registered manager may have been out of the office supporting staff or providing care. We wanted to be sure that they would be present.

Before the inspection, we checked any notifications made to us by the provider, safeguarding alerts raised about people using the service, and information we held on our database about the service and provider. This included the Provider Information Return, 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.

There were 14 people receiving regulated activities from the service, and 21 care staff, at the time of our inspection. The inspection was carried out by one inspector. During our visit to the office premises we spoke with the registered manager and office manager. We looked at the care files of the four people using the service along with the personnel files of five staff members and various other records relating to the care delivery and management of the service such as the staffing roster, training records and stakeholder surveys. The registered manager also sent us further information on request following the inspection visit.

Following the office visit, we arranged to visit two people using the service with the permission of their closest representative whom we spoke with as the involved people's complex needs meant we could not gain their views on the service. We also spoke with one of the agency's care staff and checked records during these visits. We also gained feedback from stakeholders by phone and email. In total, we gained the views of the family representatives of six people using the service, five community healthcare professionals, and two care staff.

Inadequate

Is the service safe?

Our findings

People's representatives raised no safety concerns. One person's representative told us that staff were "very aware of safety issues" such as with their family member's mobility. Another representative told us there were no safety concerns when we asked about hoisting arrangements and that the person was being transferred safely. A third representative told us the staff member was "very careful."

However, community healthcare professionals informed of two significant injuries to people whilst using the service within the last two years, one of which resulted in hospital treatment. Both instances occurred when care was being provided with a staff member from another care agency, and both were investigated under a local authority's safeguarding adults procedures. We noted that the agency was continuing to provide care to both people at the time of our inspection, and the registered manager could demonstrate that action had been taken to minimise the risk of reoccurrence. However, at the time of these accidents, care and treatment was not provided to these two people in a safe way.

Our checks of people's files found that there were no assessments for risks associated with the environment in which the service was provided, for example, to check that there were no obvious fire risks or trip hazards. There were also no risk assessments, where appropriate due to people's specific needs, in relation to falls, bed-rails, handling the person's money for shopping, or medicines. For example, one person's funding authority information identified them as at risk of falls, and in particular, not to use the stairs due to this. However, there was no falls risk assessment in place for them. These omissions put people at unnecessary safety risk.

There were ongoing assessments of risks associated with supporting people to move, skin integrity, and nutrition. However, we found that these score-based assessments were not being calculated correctly and so did not reflect higher risks involved. For example, one person's pressure care risk assessment gave a recorded total of 16 when addition of the component scores totalled 21. This occurred six times. It meant that the suggested actions as a result of the risk assessment were downgraded. We noted that the information from the funding authority included that the person had pressure care needs and so four daily visits from the agency were required. However, there was no mention of pressure care needs within the registered manager's assessment at the time of starting the service, nor in any of the seven review visits across the previous two years. The same person's nutritional risk was partially completed once in this period, despite the registered manager's assessment identifying that they needed a soft diet.

The moving and handling assessment used by the agency, whilst assessing people's needs and abilities, did not assess the environment or the equipment being used. In one person's case, the assessment recognised their support needs for showering had increased, but it failed to mention the shower chair being used, so we could not be sure that it was checked as safe for use. The assessment of the person's abilities within that assessment had not been updated for almost six months. The last update reported no change in the person's abilities, despite care records a few weeks earlier identifying the person as having increased mobility needs. Where two people were hoisted, there was no guidance on what sling was to be used and how. Environmental and equipment risks were not being identified and addressed as part of people's

moving and handling assessments.

The registered manager, who undertook all risk assessments, confirmed that she had not had specific training on assessing risk. This did not enable all relevant risks to people's health and safety to be identified and addressed. She did, however, show us that she was booked to undertake training on how to train others on moving and handling skills. She also showed us forms such as for falls and nutritional risk assessments that she said would now be used.

The registered manager told us that where the funding authority supplied a care plan, there was ordinarily no additional care plan set up by the agency. This contradicted information in the provider's service user guide that a care plan would be set up with input from the person or their representative. Two of the four people whose files we checked had no plan of care in place by the agency, either at the office, or in their own homes for staff to follow. There was therefore no individualised guidance, agreed with the person or their representatives, for matters such as safe pressure care management. This was despite one person being assessed by the registered manager as at high risk of developing a pressure ulcer. The other person had pressure care needs identified in the funding authority's information that resulted in services being provided by the agency. There was no also plan of care, to guide the agency's staff, in respect of the first person's dementia, their nutritional needs despite having diabetes, or the medicines that staff were supporting them to take.

When we checked medicines support at one person's home, the staff member gave a good account of understanding good practice in medicines. For example, they recognised that a sufficient gap was needed between doses so as to avoid the potential for overdosing. However, we found that there were no record of medicines administration (MAR) in place by which staff could record exactly what they administered to the person when. Instead, care delivery records were used, but these did not specify what the medicines were at each administration. There was no record of what the prescribed medicines were, and no medicines risk assessment to help ensure safe and proper support was provided.

The provider was subsequently unable to send us copies of MAR being used at any of the other three people they told us they were supporting with medicines, although they did show that MAR were being promptly set-up. The provider's medicines policy informed us that medicines risk assessment would be undertaken where there was medicines involvement in the care being provided, and that MAR would be used where anyone was supported to take medicines. The provider's policy was not being followed in practice.

The above evidence demonstrates a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted, however, that although risk assessments were not consistently recorded, action was sometimes taken to address risks. A staff member told us about a safety risk in one person's home that they had reported to the registered manager, from which action had been taken. The registered manager confirmed the risk and actions taken, but that there was no record of this in the person's file. Another staff member gave examples of how they made sure the person they were supporting was safe.

Of the five new care staff files we checked, appropriate references and criminal record (DBS) checks were not in place before two of the staff started working alone in people's homes. Both of these staff members had previous experience of working for a care employer, and so reasonable efforts to acquire references from those employers is required. However, records showed these two staff members were providing care, to the same person, for 16 and 24 days respectively before written references from those care employers were acquired. One of the staff members had also declared six months of ongoing work at another care employer.

However, there was no record of the provider approaching that care employer for a reference.

The provider had acquired DBS checks undertaken by previous care employers for these two staff members. This is acceptable practice where the check is less than three months old at point of application; however, they were almost four months and over three years old respectively.

We noted that there were no interview records in place for either of the above two staff members, contrary to other staff files seen. There was therefore no record of exploring a three-year employment gap declared by one of the staff members. That staff member's right to work document was found to have expired over two years ago. The management team told us they did not spot that, nor the failure to fill in questions about right to work on the application form. By the end of the day, the staff member had supplied a copy of an up-to-date right to work document. However, these points did not demonstrate safe recruitment checks at the time of recruitment.

During our staff file checks, we found that one staff member had information on their DBS check. The management team could explain a reasonable decision to employ them, however, they had not documented this, which did not assure us of a proper assessment in advance of assigning the staff member to provide care to people in their homes.

The provider's two-page recruitment policy did not give guidance for many of the above concerns. It did not refer to acquiring references from previous care employers, undertaking right to work checks, or documenting the exploration of gaps in employment. It did not state what checks had to be completed before the new staff member could provide care to people in their homes. By failing to have appropriate recruitment checks, including written references and DBS checks, in place before sending new staff to work in people's homes, the provider was not taking reasonable steps to ensure people's safety.

The above evidence demonstrates a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had safeguarding procedures in place to help protect people from abuse that included the contact details of relevant stakeholders such as the safeguarding team of local social services departments. New staff received training on recognising potential abuse and actions to take before they began working with people. Established staff received refresher training. Staff could tell us of what could constitute abuse, and knew they had to report matters, as per the policy, to the office and potentially other stakeholders such as the police if they had concerns.

We found instances where the service had taken action to protect people. The registered manager told us of instances when people's welfare had concerned her. We saw a referral to one person's social worker around ongoing concerns about their welfare, for which the registered manager told us that additional support was to be imminently provided. We saw spot-check records of the registered manager advising staff to report any healthcare concerns to the management team. Staff confirmed that they knew to report any care concerns or changed needs to the office, and were confident that the registered manager would visit to check on things. One person's representative told us that staff had reported concerns relating to another care provider involved in the care of their family member, which had ultimately resulted better care being provided.

One person's representative told us that since switching to this agency, there was no longer a lingering odour present when they visited their family member. The registered manager told us of instances where they had had to provide a cleaning service before they could take on certain care packages. Her feedback

and spot-checks of staff, along with care planning records, paid attention to upholding good standards of infection control.

Requires Improvement

Is the service effective?

Our findings

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. We found the service to be working within the principles of the MCA but that further work was required to fully embed it. Records showed that staff training on the MCA took place. The provider had a policy on the MCA that followed relevant principles; however, it was not explicit in what actions the provider would be taking with ensuring that the MCA was implemented within its services.

Within the four care files we checked during our visit, there was no direct reference to the MCA. We saw no capacity assessments, records of best interest meetings, or exploration of whether people using the service had devolved decision-making responsibilities to other people such as through a Lasting Power of Attorney. Needs assessments did not explore these matters. The registered manager told us the agency had not had to complete any capacity assessments.

Where a plan of care had been set up for one person, they had not signed consent to it and there was no record of establishing that they did not have capacity to consent to it.

We recommend that the provider review and implement best practice guidelines relating to The Mental Capacity Act (2005).

People and their representatives fed back positively about the agency's services. "I'm very impressed with them," one person's representative said, explaining this in terms of reliability, capability, thoughtfulness and helpfulness. Another representative told us their family member was much more "content" since using this agency. A third representative said, "I have greatly valued and appreciated Destiny's care, support and advice throughout," adding that the agency "on occasion has provided invaluable advice that was, strictly, outside its remit but which demonstrated that it strives for excellence." A fourth told us of no further hospital admissions for their family member since switching to this agency's services.

Most community healthcare professionals also commented positively. One told us of a high standard of care. Another informed us of receiving much positive feedback from people's representatives about care staff and the agency. A staff member, when asked what they felt proud of in their work, told us of managing to provide support to people where it had not worked out with other agencies.

The agency provided people with good healthcare support. The registered manager showed knowledge of a wide range of healthcare skills, and told of instances of raising concerns about people's health needs. For example, one person had increased mobility needs, for which occupational therapy support had been

sought. A record of the registered manager checking on staff showed that they were undertaking the physiotherapy support that had been agreed with another person using the service.

One person's representative praised the service for supporting their family member, in conjunction with the district nursing service, to no longer have a pressure ulcer. A staff member told us of how good support had been provided to help another person recover from a pressure ulcer, for which we saw records confirming that this occurred. The staff member referenced the need for regular drinks to help maintain good skin condition.

A staff member told us about the agency's interventions resulting in the recent increase in the care hours funded for one person. As a result, they explained how this would help the person with eating better. The registered manager confirmed that there was ongoing work around nutritional risks to this person. Whilst there was little documented about this on the person's file, it was evident that the agency was working effectively at improving this person's quality of life.

A staff member told us how they supported one person with eating safely in respect of their diabetic needs. They told us they had received training on diabetes. However, we noted that the registered manager's initial assessment stated that the person had a "normal diet," and the nutritional risk assessment did not identify the diabetes. This was not accurate as the funding authority assessment referenced the person's diabetes.

One community professional told us, "We know that they have skills for looking after people with dementia." A staff member we spoke with showed good awareness of dementia. The registered manager showed us that the service had many credits with the Social Care TV online training resource. We saw records confirming that it had been used for ongoing staff training and to test the quality of each staff member's knowledge on each topic. The registered manager explained that it would improve staff knowledge in areas such as for diabetes and nutrition.

For new staff, the registered manager told us that she hosted a two-day induction at which she assessed each staff member's skills and development needs in conjunction with training DVDs and a practical moving and handling session by a qualified trainer. We saw records confirming one new staff member had completed this process before starting work, but that a second had only attended one of the two days. However, that staff member told us of other training the agency had provided, and confirmed that appropriate practical components were included such as for moving and handling people. The registered manager told us there was ongoing work to convert this process into one that addressed the new national Care Certificate requirement for new staff members.

The registered manager sent us a training grid which clarified what each staff member had had training on. Whilst it did not show when each staff member needed refresher training, it did show that all staff had completed training on a number of relevant topics such as health and safety, diversity, care principles and mental capacity. There was ongoing work to ensure all staff were trained on fire safety and emergency first aid. Additionally, seven of the 20 staff had a national care qualification. We found overall that the staff supplied to provide care to people had adequate skills for their roles and responsibilities.

Good

Is the service caring?

Our findings

People's representatives commented positively about the agency's staff. One representative told us that the allocated staff member was "very caring and helpful." Another told us that when they visited their family member unannounced, staff were "always sitting with him." They added that they were contacted in good time if any supplies such as milk were running short. A third representative's comments included, "Destiny has unfailingly provided a personal, compassionate, caring and responsive service." They added that their regular staff member was willing to challenge where others providing care did not have high standards.

Staff spoke about people and the support they provided in an appropriate manner. One staff member told us of encouraging people's independence and being pleased that someone was now receiving more care as it improved their quality of life. They were aware of how to speak with people respectfully and reassuringly in situations where the person may be feeling vulnerable. Another staff member told us of the care they provided to someone who was bed-bound. They referenced appropriate equipment, "gentle rolling," and providing care as if the person were a "loved one." They also showed some awareness of the person's life history, which was important for providing appropriate care to this person who had dementia.

We saw records indicating that people were encouraged to be independent where possible. One person's care plan identified what personal care they could manage themselves and what staff had to help with.

Records showed that people usually received the same staff member across the week and from week to week. No one we spoke with raised concerns about having too many different staff. One person's representative told us that "one particular staff comes most of the time." Staff confirmed that they received similar visit rosters each week. By consistently allocating the same staff to attend to people, the agency was helping positive and trusting relationships to develop.

The provider had a policy on end-of-life care. The registered manager told us that the majority of people using the service were receiving this care, and that there was close liaison with community healthcare professionals such as palliative care nurses in these instances. A community healthcare professional said that complex care packages could be entrusted to the agency, explaining that the management team worked together with them and others to enable people, including those needing end-of-life care, to remain in their "own home with a package of care that works." Another community healthcare professional's email was positive that the service had enabled the person's last wish of dying at home. A number of cards of gratitude were received after services finished, with comments referencing the compassion and kindness shown by the agency and its staff.

The registered manager told us of how they continued to help after one person died. The person's family lived abroad and came quickly, but as the death was at the weekend, the agency provided a staff member to stay with the person's body until formal arrangements could take place. They also worked with the family, who could not speak English, to register the death. The registered manager added that they attended funerals where requested, and we saw a compliment card confirming this.

Good

Is the service responsive?

Our findings

Feedback from people's representatives indicated responsive care was being provided in practice. One representative told us that they experienced the care as "pro-active", explaining that the staff member checked on the care needed without having to be asked. This extended to making sure that supplies such as medicines did not run out, even if it was not something the staff member was supporting the person with.

The registered manager showed us a detailed needs assessment that they planned to start using. It was longer and contained more space for writing details than the one page of assessing people's needs that was currently in use across a four-page document. That document, used for all four people whose files we checked, did not include prompts for pressure care needs, the person's preferences for their care including how they wished to be addressed, relevant Mental Capacity Act 2005 information such as any Lasting Power of Attorney welfare arrangements, and information from any involved healthcare professionals. The needs assessment process was not consistently identifying people's needs and reflecting their preferences.

We noted that where there was no significant information supplied by the funding authority for one person, the agency had set up an individualised care plan. It had been kept under review and added to where the person's needs had increased. It was adjusted to reflect where they had been able to do more for themselves.

A new care plan format was being tried out for a new person that added to the care plan supplied by the funding authority. It clarified care delivery expectations to staff in a manner that identified the person's individual needs.

The service listened to and learnt from the experiences and concerns raised by stakeholders. People's representatives told us of good responses to any concerns raised, for example, "If there have been any problems they were sorted out very promptly and to our total satisfaction." Another representative confirmed that it was straightforward to talk to the office and that there was "no friction." A staff member told us that if anyone had concerns, these were reported to the office and that action was taken. They added that the office were "very good at listening to clients."

The provider had a complaints policy in place that was referred to within the service user guide given to people using the service and their representatives. The registered manager told us there had been no complaints for over two years. She gave an example of an informal concern raised by someone's family member about how the person was washed, for which they said they had instructed staff on better practice. We saw records indicating that any concerns were addressed, for example, that one person wanted a change of visit time.

Requires Improvement

Is the service well-led?

Our findings

Feedback from community professionals identified to us that the provider was not sending us notifications promptly and accurately. A recent significant injury to someone using the service whilst receiving care was not notified to us until almost two months later when we reminded the provider of their responsibility. The notification failed to mention the equipment involved in sustaining the injury. The provider also failed to inform us of a significant injury to someone from early 2015. These failures to notify us of significant injuries prevented us from monitoring the service effectively.

The evidence above demonstrates a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The management team were not able to provide us with copies of anyone's care delivery records at the office. They explained that they only acquired these after services finished. However, when we visited one person, their care delivery records dated back only two months, and we were told that the agency had removed older records. The management team confirmed that they were not checking care delivery records to ensure that people's care needs were being consistently met and changed needs were being identified. This was not good governance.

We found that records were not always accurately kept. A replacement staff member's records of the care provided at one person's home across one recent day were simply statements that all care was provided, without clarifying what the care was. This was particularly pertinent as the agency had not provided a care plan for the staff member to follow, albeit there was a live-in care worker from another agency to lead on ensuring consistent care provision. Care records made by replacement staff covering the usual staff member for another person did not include the name of the replacement staff member.

The service used a handwritten roster to record who was planned to attend at each person at what time each day. It was kept up-to-date in terms of whenever a service to someone started or finished. Our checks found that staff were usually enabled to attend to people punctually, although in one instance the same staff member was allocated to attend to two people living a few miles apart at exactly the same time.

However, the roster was not always accurately maintained. Feedback from two people's representatives showed us that sometimes a different staff member attended compared to who was recorded on the roster. In one of these cases, we checked the care delivery records which confirmed what the representative had said. It showed that different staff had provided the care compared to what was recorded on the roster. For example, a new staff member was allocated on the roster from a specific date, but care delivery records showed their presence only from 21 days later. Another person's visits on the roster did not specify the time the second staff member visited, just the amount of hours being provided each day. The roster was not therefore maintained accurately, and so could not be relied to show which staff visited people when.

There were records of spot-checks which are where a member of the management team turns up at someone's home with their permission to check on the staff member without the staff member knowing in

advance. People and their representatives confirmed that these occurred. The records showed that staff were praised for doing a good job and were guided where minor improvements were needed. However, the checks did not usually state which staff member was checked on, and so it was not possible to ensure that each staff member's practice was monitored from time to time. Five of the 18 checks we saw were missing the date of the spot-check. The records additionally did not prompt for specific checks such as punctuality, appropriate attire, respectfulness, capability and accuracy of care records. The registered manager agreed to develop the forms used.

The provider had a quality assurance policy in place. It noted an annual quality audit along with surveys of stakeholders' views. However, no quality audits were made available to us on request. If quality audits had taken place, the provider may have identified the concerns that we have highlighted in this report. As such, the provider's quality assurance policy was not being effectively followed.

The above evidence demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were four surveys shown to us about the quality of the service in 2016, from people using it and their representatives. They all fed back positively. The registered manager told us the main theme to emerge, only from a few sources, was punctuality. She had spoken with the involved staff members.

People's representatives told us the registered manager was approachable. One comment included about immediate responses and that "nothing is too much trouble for her." The registered manager told us that she worked full time between this agency and the company's small care home in Kent. However, there was also an office manager present for the agency, and all phone calls were routed to the registered manager's mobile phone whenever there was no one in the office. As such, the registered manager said she was on call at almost all times.

The registered manager showed us that she had updated her care knowledge in line with care staff expectations this year, along with a course on training the trainer which was important as she trained new staff. The nursing (NMC) register confirmed that she retrained an up-to-date nursing registration. She told us of previous management training undertaken within past employment, and that she was aiming to take further management training to keep up-to-date.

The registered manager gave many examples of how she worked in partnership with other stakeholders. This included providing feedback and raising concerns with funding authorities and social workers. There were records of issues that the registered manager had identified at spot-checks which had been fed back to funders for resolution because they were outside of the direct scope of the care that the agency was providing. For example, to acquire appropriate equipment and to get additional nutritional support. Community healthcare professionals confirmed this partnership working. One fed back positively that the registered manager "has highlighted many issues to us and has been able to solve a lot of the issues on our behalf."

Staff told us they felt supported by the management team who were always available for support if needed. They gave examples of being able to report broken equipment and where the behaviour of someone using the service had made them "uncomfortable." They told us that the management team took action in response. One staff member told us of the management team leading by example and having a "nice way" with people using the service. They added that there were regular staff meetings at which the good care of people and any difficulties were discussed. Another staff member told us that staff meetings included being asked about what they should do in specific scenarios such as if finding someone using the service fallen on

the floor. Staff feedback confirmed that supervisions took place regularly and provided an opportunity to identify individual training and support needs.

The registered manager told us that they reminded staff at the recent staff meeting about reporting any concerns or changed care needs to the management team. Minutes of the meeting broadly referred to this, along with discussing the ongoing needs of particular people using the service, ensuring punctuality, and effective communication. There was also reference to accurate care delivery records, which the registered manager explained was due to identifying that staff did not always sign these records clearly. She was therefore going to set up a staff signature sheet, to help identify different staff members.

There were six staff surveys from the previous month that indicated positive support of staff but in some cases that more training could be provided. The registered manager told us that five of the 21 current staff members had national care qualifications but that further development of staff members' skills was in progress.

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 injuries to service users that resulted in changes to the structure of the service users' bodies. Regulation 18(1)(2)(a)(ii)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care of service users was not provided in a consistently safe way. This included failure to: • Assess the risks to the health and safety of service users of receiving care; • Do all that is reasonably practicable to mitigate any such risks; • Ensure equipment used for care is used in a safe way; • Ensure the proper and safe management of medicines; • Ensure the health, safety and welfare of service users where care responsibility is shared with other persons. Regulation 12(1)(2)(a)(b)(e)(g)(i)

The enforcement action we took:

We imposed a condition on the registered provider's registration requiring them to send us monthly reports about the results their audits of service users' care plans and risk assessments, medicine administration records, staff recruitment records, and service user care delivery records, and any actions planned or taken in response to the audits.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not effectively operated to ensure compliance with the Fundamental Standards. This included failure to: assess, monitor and improve the quality and safety of the services provided; assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others; accurately and completely maintain records in respect of each service user. Regulation 17(1)(2)(a)(b)(c)

The enforcement action we took:

We imposed a condition on the registered provider's registration requiring them to send us monthly

reports about the results their audits of service users' care plans and risk assessments, medicine administration records, staff recruitment records, and service user care delivery records, and any actions planned or taken in response to the audits.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered persons failed to ensure that the following were available before employing anyone to provide care: •□An appropriate criminal record certificate •□Satisfactory evidence of conduct in previous care employment •□A full employment history, together with a satisfactory written explanation of any gaps in employment. Regulation 19(3)(a) S3 parts 3, 4, 7.

The enforcement action we took:

We imposed a condition on the registered provider's registration requiring them to send us monthly reports about the results their audits of service users' care plans and risk assessments, medicine administration records, staff recruitment records, and service user care delivery records, and any actions planned or taken in response to the audits.