Sermaw Limited

# SPN Healthcare

## Inspection report

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27 January 2017

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

SPN Healthcare is a domiciliary care agency which is registered to provide personal care support to people in their own homes. At the time of our visit the agency supported 11 people with their personal care. Many of the people being supported had a progressive illness where the focus was on palliative and end of life care. The service employed 15 care workers.

We visited the offices of SPN Healthcare on 17 and 27 January 2017. Both inspection visits were announced and we gave the provider 48 hours' notice. This was to ensure we could meet with the provider of the service and staff on the day of our first visit. Our second visit was announced to ensure the provider was available to discuss the action they told us they would take after our first visit.

This was the first inspection of SPN Healthcare since they registered with us in April 2016. The provider told us that they had been providing a service to people since September 2016.

The service had a registered manager. A requirement of the provider's registration is that they have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider is the registered manager for this service and will be referred to as 'the provider' throughout this report.

Some staff had not been recruited safely because the provider had not requested all the required pre-employment checks prior to staff starting work. This meant people were at risk of being supported by staff who were unsuitable to work with people who used the service.

Not all care workers had received an induction and the training required to meet people's needs safely and effectively. Care workers practice was not being checked to make sure they worked in line with the provider's policies and procedures. Furthermore, policies and procedures were not fully reflective of the service being provided and some were out of date.

The provider had not established effective procedures to check and monitor the quality and safety of the service people received. This meant the provider was not aware of potential poor practice and areas where improvement was necessary.

People's care records provided staff with information about how people should be cared for. Staff spoken with had a good understanding of the needs and preferences of the people they supported.

Systems to ensure medicines were managed safely were not effective. People saw health professionals when needed. Support was given to people who required help with eating and drinking.

There were enough care workers to provide care at the agreed times. People received their care and support from care workers who they knew and people and relatives were involved in planning their care.

People and relatives told us they felt safe using the service and care workers understood how to protect people from abuse.  Some risks associated with the delivery of care and support for people who used the service had been assessed. However, some risk management plans lacked detail and most risk assessments had not been reviewed.

The provider had some understanding of their responsibilities to comply with the relevant requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People's capacity to make decision had been assessed. However, where people had been assessed as having capacity, assessments lacked detail about which decision was being considered. Care workers respected people's decisions and gained people's consent before they provided personal care. People told us care workers were kind and caring.

People's privacy and dignity was respected by care workers. Where possible, care workers encouraged people to be independent. People told us care workers had a respectful and caring attitude and in their opinion had the right skills and experience to provide the care and support required.

People and relatives told us they knew how to raise any concerns and felt these would be listened and responded to effectively. Staff told us the management team were supportive.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not consistently safe.

Some staff had not been safely recruited because checks to ensure their suitability to work with people who used the service were not carried out prior to them starting work. Systems to ensure the safe management of medicines were not effective. People told us they felt safe with care workers and there were enough care workers to provide the support people required. Some risk assessment lacked detail. However, care workers understood the risks relating to people's care. Care workers knew how to safeguard people from harm and understood their responsibility to report any concerns.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

Some staff had not been inducted into the organisation or completed the training needed to ensure they had the knowledge and skills to deliver safe and effective care to people prior to working with people in their own homes. This was being addressed. The provider had a basic understanding of their responsibilities under the Mental capacity Act (2005). Staff obtained people's consent before care and support was provided. Care workers supported people with their nutritional needs and to access health care when needed.

### Is the service caring?

**Good**

The service was caring.

People were supported by care workers who they considered caring and respectful. Care workers respected people's privacy and dignity and encouraged people to maintain their independence. People were able to make everyday choices which were respected by staff.

### Is the service responsive?

**Good**

The service was responsive.

People were supported by care workers they knew and who understood their individual needs. Care calls were provided at the times people needed to support them effectively. People's care plans informed care workers how people wanted their care and support to be provided. People and relatives were involved in planning care needs. However, care plans had not been reviewed. People and relatives knew how to make a complaint, and complaints were managed in line with the provider procedure.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well-led.

The provider had not ensured that effective quality assurance procedures were in place to assess and monitor the quality and safety of the service people received. This meant that areas of poor practice in relation to the service had not been identified. People and relatives spoke positively about the service provided and felt able to speak with the management team if they needed to. Care workers said the management team were approachable and supportive. The provider was the registered manager at this service.

# SPN Healthcare

**Detailed findings**

## Background to this inspection

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

The office visits took place on 17 and 27 January 2017. Both inspection visits were announced to ensure the provider and staff had sufficient time to meet with us. The first visit was conducted by one inspector. After our first visit we had concerns about the safety, health and well-being of people who used the service. We contacted the provider on 18 January 2017 and informed them of our concerns, and asked for an action plan to be sent to us within 48 hours outlining the action they would take to ensure people's safety. We shared these concerns with commissioners of the service.

On 27 January 2017, two inspectors went back to the service to ensure actions the provider assured us they would take after our first visit, were in place. This second visit was also announced.

Before we visited SPN Healthcare we reviewed the information we held about the service, for example, the Statement of Purpose for the service.

We also conducted telephone interviews with two people who used the service and four relatives of people to obtain their views of the service they received.

During our inspection we spoke with the provider, the newly appointed care manager, newly appointed care coordinator and we conducted telephone interviews with nine care workers.

We reviewed five people's care records to see how their care and support was planned and delivered. We checked 12 staff files to see whether staff had been recruited safely and were trained to deliver the care and support people required. We also looked at other records related to people's care and how the service operated; including checks management took to be assured that people received a good quality service.

Requires Improvement

# Is the service safe?

## Our findings

People were not protected by the provider's recruitment practices. This was because the provider put people at potential significant risk by not fully understanding their responsibilities to obtain the relevant pre-employment checks to ensure staff suitability to work with people.

The provider had not requested pre-employment checks with the Disclosure and Barring Service (DBS) or obtained references for some staff prior to them working for the service. The DBS is a national agency that assists employers make safer recruitment decisions by checking people's backgrounds. This is to prevent people of unsuitable character from working with people who use care services.

On our first office visit information in staff files showed the provider had not applied for the required DBS checks or DBS Adult First checks before staff started working with people who used the service. A DBS Adult First check can permit a person to start work, in exceptional circumstances, before a DBS certificate has been received. Staff confirmed they had not been asked to complete new checks. One care worker said, "I had a DBS from my last job which I brought with me." We asked the staff member if their DBS was 'portable' they told us it was not. A portable DBS checks allows applicants to carry their DBS check across different employers. We spoke with the care manager who told us, all care worker were working with people in their homes, unsupervised. This meant there was a risk people could be supported by staff that were not of a suitable character.

We immediately discussed our concerns with the provider. We found they did not have a clear understanding of the DBS requirements. The provider showed us DBS checks which had been completed by staff members' previous employers. They told us, "I rang the DBS and was told these DBS checks were valid for a year. I was given incorrect information." They added they could not recall who and when they spoke to the DBS.

We found that risk assessments had not been undertaken where staff members' previous employment checks contained information which raised questions about their suitability to work with people who used the service. The care manager confirmed these staff were working, unsupervised with people who used the service. We asked the provider what steps they had taken to assure themselves of these staff's suitability for employment. The provider told us they had not taken any action. They said, "I have left it to the [Care manager] but [Care manager] has only been here two weeks so they haven't been done yet."

We also found references for new staff had not always been received prior to staff taking up employment. For example, two staff files showed staff had started working at the service on 3 January 2017. References on both files were dated 13 January 2017. This meant the provider had not assured themselves staff were of good character before they started work.

We were very concerned about the way in which staff were being recruited and the risk this posed to people who used the service. We therefore asked the provider to give us assurance that all the required recruitment checks to support safe recruitment decisions were completed. On 18 January 2017 the provider told us they

had made applications for new DBS checks and, where needed, risk assessments had been completed to assure the provider of staff's employment suitability.

We went back to the service on 27 January 2017 to gain assurance the actions the provider told us they would take had been completed.

Records confirmed the provider had submitted DBS applications for staff where required. Four completed DBS checks had been received and six were still being processed. The provider confirmed staff had continued to work, unsupervised, whilst waiting for their DBS checks to be returned. We asked the provider if they had applied for 'Adult first checks'. They told us they had not because their understanding was if staff had an existing DBS and a new one had been applied for, they could work unsupervised. We shared these concerns with commissioners of the service.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Fit and proper persons employed.

We looked at how medicines were managed by the service. Most relatives we spoke told us they supported their family member to manage their medicines. We found where care workers supported people to manage their medicines information was not always recorded clearly in care plans. For example, the care plan for one person included a risk assessment which listed the medicines the person was prescribed but did not include the times they should be taken or the dosage. Whilst there was information on this elsewhere in the care plan, it was hand written, was not dated and had been amended, with dosages having been crossed out and re-written. There was a MAR sheet in the care plan but this was blank. The lack of information on the MAR meant staff could be confused about how much and what time they administered the medicine. We discussed this with the provider who told us the person's medicines came from the pharmacy in a 'blister pack' which assisted care staff to administer. However, they agreed for clarity and to ensure safe support, the MAR should be completed in the care plan, and information should be dated and clearly recorded. They assured us they would take action on this.

Some staff told us they had completed on-line medication training. When we asked staff if their competency to manage and administer medicines was regular checked by a member of the management team we received mixed responses. These included, "Yes, the manager worked with me so they checked what I was doing.", "No-one has checked me, yet.", And "I honestly can't remember, but perhaps the manager did." We asked the provider if they completed observations of staff practice. They told us they had but these had not been recorded. They told us staff observations were part of the role of the newly recruited 'field supervisor'. Records showed two observations had taken place.

People who used the service told us they felt safe with the care workers who supported them. One person told us this was because care workers were reliable and the person could depend on the care visit taking place. Relatives agreed. One relative told us they were confident their family member was safe because of the care workers, "Approach, understanding and knowledge." They added care workers informed them if they had any concerns about their family member and this further reassured them of their family member's safety. People knew who to speak to if they didn't feel safe, they told us they would speak with, "The office, their relative or staff."

Care workers told us they understood the importance of keeping people who they supported safe. One care worker told us, "Safety is an important part of our job. Safety for the person and safety in the home. It's our responsibility." The care manager explained the process if they suspected anyone was experiencing harm or abuse. They told us, "We would report any concerns to the council safeguarding team or to the police if

necessary."

Records showed not all staff had received safeguarding training. However, when we talked with care workers, they were able to demonstrate they understood the different types of abuse a person may experience and understood their responsibilities to record and report any concerns. One care worker said, "I need to look out for any changes like marks (to the body) and I have to report any concerns to my manager." Some but not all staff knew about the provider's whistleblowing policy which supported them to report any concerns about other staff's practice. One care worker told us, "If I reported something and it wasn't actioned I would go straight to CQC."

On our second visit to the service we saw the provider had taken action to minimise risks of abuse, harm or neglect. Training certificates showed since our visit on 17 January, all staff had attended training in safeguarding and protecting people from the risk of abuse.

There were enough care workers available to support people at the times they preferred, and people received the support they needed. One person said, "They [Care workers] are here first thing in the morning and do everything I need." A relative informed us since the service started four weeks ago staff had 'always' arrived on time. They added, "The carers stay as long as [Person's name] needs. They never rush. It's been very positive."

The care manager confirmed there were enough care workers to allocate all planned calls people required at the times needed. They explained the care coordinator and field supervisor were also available to cover care calls when required, for example to cover any unplanned staff absences due to sickness. The care coordinator told us, "I have only been here a short while but so far staff sickness has not been a problem."

There were procedures to identify potential risks related to people's care, such as risks in the home or risks to the person. We saw some risk assessments had been completed and care was planned to manage and reduce risks. For example, one person was at risk of falling from their bed, and could injure themselves. Care plans informed care workers how the person should be assisted to move around their bed, the number of staff required, and what equipment should be in place to minimise this risk.

The risk assessment for another person stated there was a risk of seizures if the person did not take their medicines. However, there was no epilepsy management plan included in the person's care records to guide staff on how they should respond if the person had a seizure while they were being supported. We raised this with the provider, who told us the person's epilepsy was well controlled and they had not had a seizure for six years. However, they agreed there should have been an up to date epilepsy risk management plan on the person's care record and they would address this when the care plan was reviewed.

Care workers demonstrated they had an understanding of the risks associated with people's care and how these were to be managed. One care worker told us, "The care coordinator comes out on day one to do all the risk assessments. They are in the file for us to read." Another care worker said, "If we think something has changed we ring the office. We write what we do at each call and any changes, in the daily notes so the others [Staff] know what's changed. Then the [management team] come out to have a look."

We asked to see 'daily care' notes. The care manager told us there were none available because they had not been returned to the office. They explained following our first visit, they had been tasked with implementing a procedure for checking daily notes and the first were due to be returned week commencing 30 January 2016. This meant that on this occasion we could not check from records that care workers followed the instructions in risk assessments and recorded any changes to risk associated with

people's care and support needs.

There was no information to show how individual accidents or incidents were logged or analysed to identify any patterns or trends. The care manager told us they had just introduced a procedure for reporting and handling incidents and accidents, and forms were now in place so staff could record these. The care manager told us none had been recorded as yet. They added, "…but if and when they are, the forms would be analysed to look for any patterns or trends and action would then be taken to keep people safe.

Requires Improvement

# Is the service effective?

## Our findings

The induction to SPN Health Care and the training care workers received did not fully equip or support them to provide the care people required safely and effectively.

During our first inspection visit we found newly recruited staff had not completed an induction when they started work at the service. One care worker told us, "I haven't done an induction but I have been told one is being booked." Another care worker told us they had not had time to complete an induction because they started working in people's homes on their first day working for the service. This meant we could not be assured staff had a clear understanding of their role and responsibilities. The provider acknowledged new staff had not completed an induction. They told us, "It was an oversight. We were swamped with new staff coming over with [Care manager]. It was overwhelming." They told us the care manager was in the process of planning inductions for new staff.

Records showed new staff had not received all the training expected by the provider, to ensure they had the skills and knowledge to meet the health and social care needs of people who used the service. This included training in safer people handling, safeguarding adults, and health and safety. One recently recruited care worker told us, "I have done two of the online courses but I haven't had time to do others yet." Another said, "I know I need to do the training but I had problems with my online password." They told us this problem had been resolved and they were planning to start completing the on-line courses.

A relative told us of a concern they had in relation to new care workers knowledge of supporting people to move safely. They described having observed the care worker stand behind their relative and 'yank' them up the bed. The relative added, "There was another care worker there but they just stood and watched." We looked at the person's care plan during our visit, and saw the person needed support from two staff to assist them to move safely.

We asked the provider if new staff had completed training in the use of moving and handling equipment, such as a slide sheet or hoist since starting work at the service. They told us staff had not. They added, "I was told they [Staff] had done this training with their last employer but they [Staff] couldn't get copies of the certificates. I took them at their word." The provider acknowledged they had not taken steps to assure themselves staff had been trained to support people to move safely. They told us they would ensure all new staff completed 'mandatory' training, which included moving and handling and gave assurance no staff would be involved in moving people until they had received the necessary training. We shared these concerns with commissioners of the service.
When we returned to the service on 27 January we found that the provider had taken immediate action to address these issues. Six new staff members had completed an induction since our first visit. The care co-ordinator told us a further two 'induction' sessions had been arranged for the week after our second visit.

We looked at the SPN Healthcare 'Induction and Training Handbook' which we were told had been issued to staff. We found the handbook was not up to date and mainly contained information which was not relevant to the role of a care worker. For example, the handbook made repeated reference to the role of 'locums' (a

term commonly associated with professionally qualified health care professional) and to The NHS code of practice. We discussed this with the provider. They acknowledged the handbook required updating and said they were planning to amend it within two weeks so it was 'more specific to social care staff'.

Following our inspection visit the provider informed us there was a second 'Induction handbook' which was specific to staff who supported people with personal care. However, we were not aware of this on the day of our visit. The provider told us this handbook was also under review.

The care coordinator told us the 'induction' training being provided was in line with the requirements of The Care Certificate. The Care Certificate is expected to help new members of staff develop and demonstrate key skills, knowledge, values and behaviours, enabling them to provide people with safe, effective, compassionate, high-quality care. However, we reviewed the induction folder which did not include any of the care certificate standards, and there was no process in place for new staff to have their practice assessed in line with requirements of the care certificate. Both the care manager and the care co-ordinator agreed they needed more information to support staff to complete The Care Certificate.

The care manager told us since our visit on 17 January 2017 all staff had completed training the provider considered essential to enable staff to support people effectively. Certificates for this training showed staff had completed multiple training courses in one day. For example, a certificate dated 19 January 2017 and titled 'All in One-day Mandatory Training Course' listed 12 diverse and different topics, such as Safeguarding (adults and children), Health and Safety, Moving and Handling (practical), Equality and Diversity and Infection Control.

This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

We had concerns about the quality of the training and the knowledge and understanding care workers would gain from completing so many courses in such a short period of time. We discussed our concerns about staff training with the provider. They said, "When it's big groups you can't be sure they [Staff] are listening or taking it in. They could be falling asleep." They explained all future training would be delivered by the care coordinator so they could be assured staff training was effective.

We asked the care coordinator about staff learning and understanding of the training completed. The care co-ordinator acknowledged the way training had been provided was a lot to cover in one day, but said this would be followed up through supervision and observation of practice, and that more in depth training in key areas would be arranged once they had completed the 'train the trainer' courses.

We asked if staff had completed specialist training, particularly because many people using the service were in receipt of palliative care as they approached the end stages of their lives. The provider told us staff had not completed 'end of life' training. They added this was something they were planning to arrange. The care co-ordinator told us a number of staff had recently completed training on percutaneous endoscopic gastroscopy (PEG), provided by local nursing staff. A PEG is a way of providing food and drink through a tube inserted in a person stomach when the person cannot take food orally. Staff told us they had found the training valuable. One care worker said, "Since I did the training I feel more confident when I am supporting [Person's name]."

The care co-ordinator showed us a training matrix which would be used to record the training staff had undertaken to ensure they had the right skills and knowledge to support people. The matrix recorded one training session for one member of staff only, and we were told it was a 'work in progress'. The provider told

us some staff had already undertaken online training in areas such as epilepsy. They explained when allocating care calls, they would ensure people with specific needs, such as epilepsy, were supported by staff who had some training in the area. We pointed out online training was not currently recorded on the matrix. The provider gave assurance it would be recorded immediately.

When we asked staff if they had individual opportunities to meet (staff supervision) with a member of the management team we received mixed responses. These included, "Yes, I have met with the manager to talk about things.", "No, I don't think I have ever had a meeting.", And "I had my first one [supervision] last week. It was ok." The provider told us they had completed supervision with all staff who joined the service prior to January 2017, but these sessions had not been recorded. They told us the care manager was in the process of planning sessions for all staff. Records showed some individual meetings had already taken place.

People told us that in their opinion, care workers who visited them had the skills and knowledge needed to support them effectively. One person said, "They know how to help me." Another person said, "My carers are very good. They must be trained else they wouldn't know what to do." A relative commented, "I am sure the carers are trained. If there were any issues [Family member's name] would have told me."

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. Where people lack mental capacity to take particular decisions, any decisions made must be in their best interests and in the least restrictive way 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 are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. The provider had a basic understanding of MCA, their responsibilities under the Act and how they should put this into practice.

The care coordinator told us MCA assessments were completed with people and their relatives by a member of the management team during their initial assessment. They told us, "This information is all entered on to risk assessments whether someone has capacity or not. This would then be linked to the support plan." We saw people's care plans included completed capacity assessments. However, these were not decision specific so it was not clear which decisions people were being assessed for. The provider told us this was an area they were planning to improve through staff training.

When speaking with staff about the MCA care workers who had completed training demonstrated they had a good understanding. For example, one care worker told us, "It's all about the mental ability to make decisions. If you can make some decisions, but not others then someone can be appointed to make those decisions in your best interests." Care workers said everyone they supported could make everyday decisions for themselves or had someone who could support them to do this. Care workers who had not received training had little understanding of how this could affect their practice. However, all staff we spoke with understood the importance of receiving consent from people before they undertook any tasks to support people. One care worker told us, "We are there to help people and do what they want. We never do anything until they [People] have agreed."

People and relatives told us care workers obtained their consent before assisting with care and support. One person said, "The girls start by asking me if they can help me. They ask every time." A relative described how care workers 'always 'explained what they were going to do and asked their family member if this was 'ok' before they provided any care and support.

Most people we spoke with prepared their own food or had relatives that supported them with this. People who were reliant on care workers to assist with meal preparation told us choice was offered and drinks were given where needed. One person using the service was supported with food and medicines via a PEG. The person's care records included information for staff on how to manage this safely, what they should look out for and how to escalate any concerns to health professionals. This helped to keep people safe and to ensure specialist needs were met.

All the people and relatives we spoke with managed their own healthcare or had relatives that supported them with this. Care workers said they would inform the office if a person needed a visit from their GP but said family would usually do this. Records confirmed the service involved other health professionals with people's care when required including district nurses, occupational therapists and GPs. Where needed people were supported to manage their health conditions and had access to health professionals if required.

Good

# Is the service caring?

## Our findings

People and relatives spoke positively about the care workers who supported them. Comments made included, "They are wonderful.", "All of them are kind, thoughtful and think of the customer first." And, "The carers are friendly, respectful and caring."

We asked care workers what being 'caring' meant for them. One care worker told us, "Being respectful and thinking of the client as family members." Care workers told us about how they built relationships with the people they supported, this included learning about what was important to people, talking and listening to people, and ensuring people's choices were respected. One care worker told us this approach ensured people felt 'in control' of their lives. They added, "This is really important because we help people who are dying."

People's privacy and dignity was respected by care workers. One person said, "They always knock the front door and ask if they can come in." A relative told us, "When they [Care workers] are in the bedroom they ask if I would mind waiting till they tell me I can come in." The relative explained they understood this was to protect their family member's privacy. Care workers told us they understood the importance of promoting people's dignity and privacy. One said, "I always think how I would feel if I needed help. I understand it can feel embarrassing so I try to make sure I do everything to help. Like using a towel to cover private parts."

People and relatives told us they were involved in making decisions about their care and had been involved in planning their care when they started to use the service. One person said, "They [Management] came out to talk about what I needed." A relative told us the service provided by SPN Healthcare was their first experience of social care support. They said, "I was apprehensive but that was short lived. We have been fully involved in planning [Family member's] care. It feels like we all work together. "

People were supported, where possible, to maintain their independence and the support they received was flexible to their needs. One relative told us, "[Person's name] is very poorly. Some days are better than others but the girls [Care workers] still encourage [Person's name] to do things themselves, in a sensitive way." Another relative told us care workers asked their family member at each care call what help they needed. They told us this was because their family member's needs changed on a daily basis. A care worker told us all the people they visited were entering the end stage of life. They said, "Even though they [People] are so ill you can see how good they feel when they have managed to do something with only a little help. It's really important to remember this."

We saw records in the office that contained personal information were secured and kept confidential. Care workers told us they understood the importance of maintaining people's confidentiality. One told us, "If I need to talk to the office about one of the clients I go outside or I sit in my car."

Good

# Is the service responsive?

## Our findings

We looked at five people's care records. Care plans were written in a personalised way, and included some information for staff on people's likes, dislikes, preferences and history. Plans included instructions for care workers about what to do on each visit. For example; what personal care support people required and how staff should support people who required assistance or equipment to move around.

People and relatives told us they were very satisfied with service they received because the service was reliable, was provided by care workers they knew, and who were responsive to people's needs and preferences. One person said, "[Person's name] needs change day by day but absolutely nothing is too much trouble for the carers. Wonderful."

Prior to the service starting, people were assessed by a member of the management team to ensure their needs and expectations could be met. A relative told us, "The assessment was very detailed and I was fully involved." The relative added, "They [Care coordinator] prompted me to think about everything that is important to [Family member's name]. It was most helpful."

Care workers had a good understanding of people's care and support needs. They told us this was because they had a set rota which meant they visited the same people. One person told us, "Continuity is really important for [Person's name]. So getting the same staff has really helped." One care worker told us "I only work with one client [Person] so I know them really well." Another care worker told us, "Because we don't have many clients [People] we know all of them and they know us."

We looked at the call schedules for three people who used the service and three care workers. These confirmed care calls were planned in advance, at the times agreed and people were allocated regular care workers. A person told us, "It's early days but so far the service has been absolutely reliable." The care manager told us, "All our staff work in teams to provide continuity. This is very important especially when someone is dying. It's important for the person and their family to be able to build a relationship with the carers."

All the people and relatives we spoke with told us care workers had sufficient time to carry out care calls without having to rush and had flexibility to stay longer if required. One person told us, "They [Care workers] always take their time. In fact they make time to have a chat." A relative said, "The carers are wonderful. They go at [Person's name] pace." When discussing the time allocated for calls with care workers we were told, "We have plenty of time to do our calls. I hope it stays like this when we get more clients." And, "What I like is we get time to do things properly and we have time to talk to people and their family. So you can build a relationship."

Care workers told us they had time to read care plans. One said, "Reading the care plan is very important because they hold everything you need to know for your call." Another care worker told us, "If anything has changed the office ring to tell us. Then when we go to the client [Person] we start by re-reading the care plan."

We looked at how complaints were managed by the provider. People and relatives told us they had no complaints, knew how to complain and would be confident to raise any concerns with the provider if they needed to. One relative told us, "If there was anything wrong I would not hesitate to telephone [Provider]. From my contact with them so far I feel confident any worries would be listened to and dealt with." Another relative told us, "I have had absolutely no reason to complain, but I have the contact number for the manager if I need it."

Care workers knew how to support people if they wanted to complain, we were told, "Information about how to make a complaint and the number to ring is shared with clients [People] and their relatives when the service starts." Care workers told us they would refer any concerns people or family members raised to a member of the management team and they were confident concerns would be dealt with effectively.

Records showed the service had recently started to record comments and complaints. One complaint had been received which had been managed in line with the provider's policy and procedure.

Requires Improvement

# Is the service well-led?

## Our findings

The provider did not have suitable systems and processes in place to assess and monitor the quality and safety of service provided to people. For example, medicine records had not been audited and staff competencies to support the administration of medicines had not been consistently assessed. This meant we could not be assured the provider was identifying and managing risks related to the health, safety and welfare of people who used the service.

The provider told us quality assurance processes was an area they 'intended to focus on now' following the appointment of a care manager. They said this area of their responsibility had been 'overlooked' because they had been covering care calls whilst staff recruitment took place. The care manager told us they had been 'tasked' with developing and implementing processes to audit the quality and safety of the service provided. They said this was a priority because prior to them joining the organisation no audits had been completed.

A lack of auditing procedures meant the provider was not identifying areas where improvements needed to be made, and was not ensuring the service was safe and continuously improved.

The provider's policies and procedures had not been consistently followed. For example, the provider had appointed staff prior to the completion of 'an SPN issued DBS check' as specified in the provider's handbook.

The procedure for 'Staff monitoring and review of care records' stated 'care files will be reviewed within four weeks of the service start date and thereafter at regular intervals'. However, we found care records had not be audited or reviewed. This meant shortfalls in care records we identified during our inspection visit had not been addressed. We asked the provider why care records had not been reviewed and updated. They told us this was because the service had only been supporting people for eight weeks (since November 2016). Records we reviewed showed some people had been using the service since September 2016.

All staff we spoke with told us they had not attended a staff meeting since they joined the service, including a care worker who had worked for the service for five months. The provider's procedure for 'Staff meetings' stated, 'The domiciliary care manager is responsible for convening staff meetings on a monthly basis'. However, the care manager told us plans were in place for a staff meeting to be held.

We found some of the provider's policies and procedures were not up to date and some were not reflective of the service provision. For example, a number of documents made reference to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This legislation has been replaced with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider acknowledged the need to update their policies and procedures. They said, "I know they need to be clear, succinct and relevant to the target group." They told us this was something they were planning to do now they had appointed a care manager.

We were concerned the lack of effective systems to monitor the quality and safety of services provided to

people had the potential to put people's safety and wellbeing at significant risk.

This was a breach of Regulation 17 (1), (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good Governance).

The service had a registered manager who was also the provider for the service. The provider told us they had recently recruited a care manager, a care coordinator and a field supervisor. These staff had been in post for two weeks. The provider said strengthening the management team would enable them to allocate time to developing the business, including systems, processes and quality monitoring, with other members of the management team taking responsibility for day to day operations of the service.

People who used the service and relatives spoke positively about the way SPN Healthcare was managed and the quality of service provided. Comments made included, "Communication is very good. We are kept up to date.", "We couldn't have asked for more. The service has been good." And, "I think the service is well managed. Everything has been really organised."

We asked people and relatives what could be improved, one person said, "I really can't think of one thing." A relative told us, "The service has been wonderful. They couldn't do better." We saw the care manager had devised a 'Customer satisfaction survey' which had been sent out to five people, and so far one had been returned. They explained they planned to send these out on a monthly basis, and that the results of these surveys would be collated and actions taken in response to what was identified.

Care workers told us they felt supported by the management team. They said this was because a member of the management team was always available to provide support and guidance. One care worker told us, "I find it good. Even when the office is closed we have a number to ring if we need help." Another told us, "I haven't met the new manager [Care manager] but we have spoken on the phone and they were helpful. Very approachable." We observed the care manager and care coordinator spent time talking over the telephone with care workers providing advice and support, when required.

Staff described SPN healthcare as a good place to work. One care worker said, "It's early days for me but so far it's good because we work in pairs and we have time to do our calls properly." Other care workers said they enjoyed working at the service because they were able to spend time with the people they supported and their relatives. One care worker said, "Having time to listen to their [People and relatives'] worries makes me feel like I have done something worthwhile."

During our first visit to the service on 17 January 2017 we asked the provider about their responsibility to submit statutory notifications because we had not received any notifications since the service was registered. A statutory notification is information about important events which the provider is required to send to us by law. The provider demonstrated they had a basic understanding of the requirements. On our second visit to the service the provider told us they had downloaded guidance from the CQC website to update their knowledge and understanding.

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 17 HSCA RA Regulations 2014 Good governance<br><br>17 (1) The provider had not established and was not operating effective systems to ensure they assessed and monitored their service.<br><br>(2) (a) The provider was not conducting regular audits of the service to assess, monitor and improve the quality and safety of the service.<br><br>(2) (b) The provider had not ensured risk to people who used the service was continually monitored. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>19 (1) (a) The provider had not ensured staff were of good character prior to them working for the service.<br><br>19 (1) (a) The provider had not taken appropriate action on receipt of information that suggested staff may not be of suitable character to support vulnerable people in their own homes.<br><br>19 (2) The provider did not have effective recruitment procedures.<br><br>19 (2) The provider had not ensured required pre-employment checks were completed prior to staff starting work at the service. |

| Regulated activity | Regulation |
| --- | --- |
| Personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>18 (2) (a) The provider did not ensure staff completed an induction programme to prepare them for their role before working in people's homes unsupervised.<br><br>18 (2) (a) The provider had not ensured training, learning and development needs of individual staff had been completed at the start of their employment.<br><br>18(2) (a) The provider had not ensured staff were supervised until they demonstrated acceptable levels of competence to carry out their role unsupervised. |