Care Quality Commission

Leyton Healthcare (No. 12) Limited

Apple Court Care Home

Inspection report

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Cheshire
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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection was unannounced and took place on the 11 September 2015. A second day of the inspection took place on the 14 September 2015 which was announced in order to gather additional information.

Apple Court Care Home is a purpose built care home located in the centre of Warrington. It offers accommodation, personal and / or nursing care for up to 67 older people with memory problems associated with dementia. At the time of our inspection the service was providing accommodation to 51 people.

At the time of the inspection there was no registered manager at Apple Court Care Home. 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 home was previously inspected in April 2015. We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in

Summary of findings

relation to safeguarding people from abuse and improper treatment; meeting nutritional and hydration needs; receiving and acting on complaints and staff training. We received a provider action plan which detailed that the provider would take immediate action to meet the relevant regulations.

We found that the provider had taken appropriate action to safeguard people from abuse and improper treatment. Likewise we found that the provider had taken appropriate action in response to complaints; meeting nutritional and hydration needs; receiving and acting on complaints; staff training and improved governance arrangements.

During this inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and 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.

We found that registered person had failed to ensure that the people using the service were protected against the risks of unsafe or inappropriate recruitment practice as some key records had not been obtained.

Apple Court was being managed by two regional managers at the time of our inspection as the newly appointed manager was on annual leave. We have since been notified that this manager has resigned from post.

During the two days of our inspection, people living at Apple Court were observed to be comfortable and relaxed in their home environment and in the presence of staff.

People using the service and relatives spoken with were generally complimentary about the care provided at Apple Court.

For example, comments received included: “I feel safe and have no problems”; “I think it’s a lovely place”; “It is so clean. They clean everyday”; “They got the doctor out to my knee straight away”; “I am very well looked after. I couldn’t grumble about anything and the food is excellent”; “Staff are very good”; “You don’t go short of care”; “They respect you”; “Helping you isn’t too much trouble” and “We have new management. They are very open and honest about issues. They care and work hard.”

Some people raised concerns regarding the lack of activities, the use of agency staff and the standard of communication between staff. We have shared these concerns with the management team who assured us that they would take action to address the issues.

People using the service had access to a choice of wholesome and nutritious meals. Records showed that people also had access to a range of health care professionals (subject to individual need).

Systems had been developed by the provider to assess the needs and dependency of people using the service; to obtain feedback on the standard of care provided and to respond to safeguarding concerns and complaints.

We found that care planning records were in need of review to develop a more person-centred model. There was also conflicting information in some records which may have put people at risk. We also found that there remained some gaps on the training matrix and the quality assurance system was in need of review to demonstrate that the views of people using the service and their representatives were acted upon. We have made recommendations about these areas in the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

Recruitment practice did not provide adequate safeguards to protect people using the service from unsafe staff.

Requires improvement

Is the service effective?
The service was not always effective.

Gaps in a range of key training areas were noted such as dysphagia, clinical training for nurses and investigation training for managers within Leyton Healthcare. This remains in need of review to safeguard the welfare of people using the service.

Requires improvement

Is the service caring?
The service was caring.

Staff were observed to communicate and engage with people in an appropriate manner and people using the service were seen to be relaxed and at ease in the company of themselves and the staff supporting them.

Good

Is the service responsive?
The service was not always responsive.

Care plans were in need of development and review and contained conflicting information that could result in the delivery of incorrect care.

There was no activity coordinator in post at the time of our visit and people were dissatisfied with the limited range of activities on offer.

Requires improvement

Is the service well-led?
The service was not always well led.

Apple Court did not have a registered manager in post to provide leadership and direction.

The quality assurance system was in need of review to demonstrate that feedback from people using the service and their representatives was acted upon.

Requires improvement

Apple Court Care Home

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was unannounced and took place on the 11 September 2015. A second day of the inspection took place on the 14 September 2015 which was announced in order to gather additional information.

The inspection was undertaken by two adult social care inspectors.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR) which was returned to us. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We also looked at all the information which the Care Quality Commission already held on the provider. This included previous inspections and any information the provider had to notify us about. We invited the local authority to provide us with any information they held about Apple Court Care Home and the Clinical Commissioning Group. We took any information provided to us into account.

During the inspection we talked with 10 people who used the service and six visitors. We spent time with people in the communal lounges and in their bedrooms with their consent.

Furthermore, we met with two regional managers from Leyton Healthcare (the provider) who were managing the home in the absence of the newly appointed manager. We also spoke with two nurses, four care staff and the handyman.

We undertook a Short Observational Framework for Inspection (SOFI) observation in one unit of Apple Court Care Home. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at a range of records including: five care plans; three staff files; staff training; minutes of meetings; rotas; complaint and safeguarding records; medication; maintenance and audit documents.

Requires improvement

Is the service safe?

Our findings

We asked people who used the service or their relatives if they found the service provided at Apple Court Care Home to be safe.

People spoken with confirmed that they felt safe and some people qualified this. For example, we received comments such as: “I feel safe and have no problems”; “I think it’s a lovely place”; “It is so clean. They clean everyday”; “I’ve never heard anyone shout at anyone”; “I now feel safer” and I’m fine here.”

We looked at a sample of recruitment records for three staff that had recently commenced employment at Apple Court. In all files we found that there were application forms, references and proofs of identity. None of the files contained satisfactory information about any physical or mental health conditions relevant to the person’s capability to perform tasks and one file did not contain evidence of a DBS (disclosure and barring service check). This has the potential to place the welfare of vulnerable people at risk of unsuitable staff. We raised this issue with the regional management team so that action could be taken to address the matter.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to ensure that the people using the service were protected against the risks of unsafe or inappropriate recruitment practice as some key records had not been obtained.

The registered provider (Leyton Healthcare) had developed internal policies and procedures to provide guidance to staff on ‘Safeguarding Service User’s from Significant Risk of Harm’; Safeguarding Service Users from Abuse’ and ‘Staff Whistle Blowing’. A copy of the local authority's safeguarding procedures was also in place for staff to reference.

Discussion with two regional managers and staff together with examination of training records confirmed the majority of staff had completed 'safeguarding’ training which was refreshed every three years. When we talked with staff they confirmed that they had received this training which had also been included in their induction.

The regional managers and staff spoken with demonstrated a satisfactory understanding of the concept of abuse, awareness of their duty of care to protect the people in their care and the action they should take in response to suspicion or evidence of abuse. Staff spoken with also demonstrated awareness of how to whistle blow, should the need arise.

Records held by the Care Quality Commission (CQC) indicated that there had been no whistleblower concerns in the past twelve months. CQC had received negative feedback on the service via web forms; however no concerns had been received since our last inspection in April 2015.

We viewed the safeguarding file for Apple Court. A tracking form was in in place which detailed that there had been six safeguarding incidents since our last inspection in April 2015. Records confirmed that appropriate action had been taken in response to each incident which included safeguarding alerts being made to the local authority. Outcomes had also been recorded once notified.

We looked at five care plans for people who lived at Apple Court and we saw that they contained a range of risk assessments relating to different areas of care relevant to each person. We found that these had been kept under review however some information in care plans contained conflicting information.

For example, one assessment indicated that a person required a soft diet and normal fluids however the care plan stated that the person had a normal diet and ate well. Likewise, a mental capacity assessment for another person indicated that the individual lacked capacity to make decisions around areas such as finances, nutrition and medication whilst the assessment stated that the person understood and administered their own medication.

This contradictory information could result in people being placed at risk due to unsafe care being delivered. We raised these examples with a regional manager who informed us that a nurse from another home had been brought in to review all care plans and ensure consistency in care plan documentation.

We saw that staff weighed and recorded people’s weights and completed nutritional intake and fluid charts where necessary so as to identify any nutritional risks. We also

Requires improvement

Is the service safe?

noted that action had been taken to involve multi-disciplinary team members such as GPs, speech and language therapists, dieticians and mental health practitioners when necessary.

At the time of our inspection the service was providing accommodation and care to 51 people with residential or nursing needs for older people with memory problems associated with dementia.

We spoke with the two regional managers and checked staff rotas which confirmed the information we received throughout the inspection about the numbers of staff on duty. Since our last inspection the staffing levels had been reviewed. Staffing levels were two registered nurses during the day and at night. During the day, there was also one senior carer and 15 carers on duty. This reduced to eight carers at night.

We noted that individual dependency assessments were available on files viewed. A dependency tool was also in place which the management team used to monitor dependency levels and calculate staff deployment hours. We noted that since our last visit the service had reduced the number of nurses on duty through the day by one person and had increased the number of care staff on duty during the day by four people. Likewise, during the night, the staffing levels had been increased by two staff. We were informed that these changes had been made to respond to the needs of people using the service and to ensure the development of the service.

We checked the arrangements for medicines in the home with a unit manager. We saw that there were policies and procedures in place relating to the administration of medication and the use of oxygen and medical gases.

We saw that photographs of the people using the service had been attached to medication administration records to assist staff in the correct identification of people who required medication and that a list of staff responsible for administering medication, together with sample signatures was available for reference.

We noted that there were appropriate storage facilities for medication and separate storage facilities in place for medication requiring cold storage and for controlled drugs.

We saw that a record of administration was completed following the administration of medication in each instance on the medicines administration record (MAR). We also checked the arrangements for the storage, recording and administration of controlled drugs and found that this was satisfactory.

Systems were also in place to record fridge temperature checks and medication no longer required / destroyed. Additionally, 'random medication audits' and detailed 'medication audits' were completed periodically.

Training records viewed confirmed that staff responsible for the management and administration of medication had received medication training that was refreshed every three years.

We noted that the regional management team maintained an ongoing record of accidents and incidents within Apple Court. Separate records of action taken in response to incidents was also in place.

Requires improvement

Is the service effective?

Our findings

We asked people who used the service or their relatives if they found the service provided at Apple Court Care Home to be effective.

Comments received included: "They got the doctor out to my knee straight away"; "The food is great"; "I am very well looked after. I couldn't grumble about anything and the food is excellent" and "I get plenty to eat and drink."

We also received negative comments about the quality of food and this was shared with the management team so that action could be taken.

Examination of training records and discussions with staff confirmed staff had access to a range of induction, mandatory and other training that was relevant to individual roles and responsibilities. The training was delivered via e-learning or face to face sessions via one training provider.

Training available included Induction; Food Hygiene, Fire; Medication; First Aid; Health and Safety; Moving and Handling; Infection Control; Challenging Behaviour; Dementia Care; Dementia Care; Nutrition; Safeguarding; Mental Capacity and Deprivation of Liberty; falls, pressure sores; Equality and Diversity; Control of Substances Hazardous to Health; Fire Warden; National Vocational Qualifications, Dysphasia and Person Centred Care.

We checked the records of training and found that since our last inspection in April 2015 the provider had commissioned its preferred training provider to deliver a range of training to staff in areas such as: the prevention and management of falls; nutrition and wellbeing; fire training; infection control; challenging behaviour; food hygiene and health and safety; Mental Capacity Act and Deprivation of Liberty Safeguards; basic life support; safeguarding; Moving and Handling and report writing. Two nurses had also commenced the 'six steps' training programme in end of life care.

The regional managers reported that they had not managed to source dysphagia training and had also attempted to access a range of training from the Warrington Clinical Commissioning Group (CCG) but had been unsuccessful to date. Consequently, there had been no change to the number of staff who had completed dysphagia training as the provider had struggled to access appropriate training on this subject.

As a consequence the regional manager had developed a 'dysphagia competency assessment' which was due to be rolled out to all staff in the next few weeks. A swallowing risk assessment flow chart had also been obtained from Warrington Clinical Commissioning Group to help staff identify the risk of aspiration / choking and to guide the management process for the condition. We saw copies of this document on files viewed.

Following completion of our inspection we received an email from a regional manager confirming that dysphagia training had been sourced and provided for staff. We were also informed that additional clinical training was to be provided for nursing staff.

We noted that all nursing staff in post had completed CPR training however the training matrix did not provide information on which senior managers within Leyton Healthcare had completed investigation training.

We were notified that investigation training for managers and senior managers was to take place towards the end of November to include the manager and deputy manager of Apple Court once appointed. This will help to ensure senior staff have the necessary skills to undertake in depth 'root cause analysis' of untoward incidents as highlighted by a coroner following a recent inquest. We noted that an investigation report and action plan had also been completed in response to an incident since our last inspection by a senior manager and forwarded to the coroner as requested.

Discussion with staff and examination of records confirmed staff and nursing staff meetings had taken place periodically. Likewise, staff had accessed formal supervision meetings with a member of the management team. We noted that since our last inspection all staff had received a minimum of one group supervision to bring all staff up-to-date. Records sampled confirmed this information was correct.

Each of the four units within Apple Court had dining areas which were provided with food from a central kitchen. Meals were transported to each of the units via hot trolleys.

Requires improvement

Is the service effective?

The most recent local authority food hygiene inspection for Apple Court was in November 2013 and the home had been given a rating of 5 stars.

We spoke with the cook on duty and noted that information on the preferences and special dietary requirements of the people living in the home had been recorded for daily meals.

We noted that a three-week rolling menu was in operation which offered a choice of meal at each sitting. Mid-morning and afternoon snacks and an evening supper were also provided and people were observed to have refreshments throughout the day.

The menu for the day was on display in the dining rooms on a chalk board and a pictorial menu was available to help people with cognition and communication difficulties make meal choices.

We observed lunch time meals being served in one unit. Tables were attractively laid with a floral decoration, together with condiments. Each setting had a place mat with cutlery and napkin. The dining room was spacious, light and pleasantly decorated.

People were offered drinks and a choice of meal. We noted that staff were available to offer encouragement and support to people requiring assistance and that staff were attentive to the needs of people using the service.

Apple Court has four units. The 'Rylands', 'Grosvenor' and 'Daresbury' units provide nursing care for up to 50 people. The 'Crossfields' unit provides personal care for up to 17 people. Each unit is equipped with a dining room and a lounge area.

People who live in the home are accommodated on both floors of the two storey building and access between the first and second floors is via passenger lift or by the stairway. Each unit is equipped with a dining room and a lounge area. Bedrooms are all single, with en-suite facilities that include a sink and toilet.

We noted that the corridors within the units of Apple Court had been decorated with collages on the wall and were themed around topics chosen by residents such as Coronation Street, Chester Zoo and Blackpool. Toilet and bathroom doors had also been painted in bright colours to help people orientate around the home. In addition memory boxes (door signage frames) had been fitted to doors to help people identify their rooms. We saw that people's rooms were also personalised with pictures, photographs, blankets and throws; ornaments and other memorabilia.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. DoLS are part of this legislation and ensure where someone may be deprived of their liberty, the least restrictive option is taken.

We saw that there were corporate policies in place relating to the Mental Capacity Act 2005 and DoLS and that staff had access to training in this area.

Discussion with the regional managers and examination of records indicated that 51 mental capacity assessments had been completed for people living at Apple Court. Records detailed that 14 people were subject to a DoLS authorisation at the time of our visit. Several additional DoLS applications had also been made, which the service was waiting to hear the outcome of from the local authority.

Staff spoken with were able to describe where DoLS might be applicable and confirmed they had received training. One agency staff member spoken with lacked awareness of which people using the service were subject to a DoLS authorisation. This uncertainty meant that these safeguards might be applied to the wrong person or might not be applied correctly. This was raised with the regional manager who agreed to address the matter.

Care plan records viewed provided evidence that people using the service had accessed a range of health care professionals including: GPs; occupational therapists; community psychiatric nurses; dieticians etc. subject to individual needs.

We recommend that the outstanding training needs of all staff are reviewed.

Good

Is the service caring?

Our findings

We asked people who used the service or their relatives if they found the service provided at Apple Court Care Home to be caring.

Comments received included: “Staff are very good”; “You don’t go short of care”; “They are smashing people”; “They respect you” and “Helping you isn’t too much trouble.”

We spent time with people and staff on each of the units in the Apple Court over the two days of our inspection. We observed that interactions between staff and people using the service were generally friendly, polite and unhurried.

The two regional managers that were overseeing the management of Apple Court in the absence of a home manager demonstrated a commitment to the ongoing development of the service and the promotion of good standards of care.

Our use of the Short Observational Framework for Inspection (SOFI) tool found interactions between staff and people using the service were positive, dignified and kind. Staff were observed to communicate and engage with people in an appropriate manner and people using the service were seen to be relaxed and at ease in the company of themselves and the staff supporting them.

We asked staff how they promoted dignity and privacy when providing care to people at Apple Court. Staff told us that they had received induction and training on the principles of person centred care. It was evident from speaking to people using the service and direct observation that staff applied the principles of treating people with respect, safeguarding dignity and privacy and promoting independence and choice in their day-to-day duties. People using the service appeared relaxed and comfortable and we saw that visitors attended throughout the day without restriction and were made welcome with drinks.

A number of bedroom doors were noted to be open whilst walking around Apple Court. It was therefore evident to see that people using the service had been supported to personalise their rooms with pictures; photographs; fresh fruit and ornaments and other personal possessions and memorabilia. People spoken with confirmed that they wished for their doors to be left open.

Information about people who lived at Apple Court was kept securely to ensure privacy and confidentially.

A statement of purpose and a guide for new residents was available for prospective service users and people using the service to view. These documents contained a range of information about Apple Court, the aims and objectives of the service, philosophy of care and how to raise a complaint.

Requires improvement

Is the service responsive?

Our findings

We asked people who used the service or their relatives if they found the service provided at Apple Court Care Home to be responsive.

Comments received included: "I'm happy as they are on hand and do things for you"; "I am happy with the care and have no complaints"; "Staff come immediately. I would recommend this place to anyone" and "I have no complaints. The staff are okay. They are fine."

One relative spoken with during our inspection raised a number of concerns regarding the standard of care provided to a relative. The concerns were regarding the use of agency staff and continuity of care; personal care and communication between staff. We raised these issues with the regional management team who assured us that action would be taken to improve matters.

A number of people using the service and their representatives expressed concern regarding the lack of activities available to people using the service. We raised this issue with the regional management team who informed us that the activities coordinator had recently stepped down from her role. We noted that the vacancy had been filled and that a replacement person was due to start in this role within a month. The provider had also increased the number of hours for this role so that an additional activities coordinator could be recruited to post. This post had also been recruited to and the person was due to commence employment shortly.

The provider had developed a complaints policy to provide guidance to people using the service, their representatives and staff on how to raise and / or manage a complaint.

We reviewed the complaints file. Records highlighted that there had been ten complaints since our last inspection in April 2015. Records viewed provided an overview of complaints received, action taken and outcomes. Copies of formal response letters were also available for reference.

People using the service and relatives spoken with told us that in the event they needed to raise a concern they were confident they would be listened to and the issue acted upon promptly.

Apple Court was divided into four units. The 'Daresbury'; 'Grosvenor' and Rylands units provided nursing care and support for a combined total of up to 50 people living with dementia who required general nursing care. Likewise, the 'Crossfield' unit provided residential care for up to 17 people living with dementia. Dementia can cause memory loss, confusion, mood changes and difficulty in functioning and coping with day-to-day tasks. Since our last inspection the regional management team had integrated the lounge and dining areas on the ground and first floor to enable better supervision and support for people using the service.

We looked at five care files and found copies of corporate documentation that had been developed by the provider (Leyton Healthcare).

Care plan records viewed contained assessments of need; care plans and risk assessments together with a range of supporting documentation such as daily care notes, incident records and observation charts.

We noted differences in formats and the detail of information recorded. Care plans were found to be standardised and there was scope for the development of a more personalised approach to care planning within the home. Furthermore, although there was evidence that care plans had been kept under monthly review we noted gaps and conflicting information in some records.

We found that a care plan for risk of choking and aspiration had been updated since our last inspection to provide clear instructions for assisting with feeding to ensure appropriate guidance for staff. We also noted that the care plans within Apple Court were in the process of being updated to ensure consistency and improve records.

Staff told us that they were given time to read people's care plans and risk assessments to help them understand the needs and support requirements of people using the service. Care files we looked at included a staff signature list which confirmed that staff had read care plans and other supporting documentation.

Staff told us that updates on people's needs were discussed at the handover during shift changes, via the daily reports and informally with senior carers.

Key information on Apple Court was available in the reception area and documents such as the home's statement of purpose, service user guide and complaints procedure was available for reference.

Requires improvement

Is the service responsive?

We recommend that care planning records are continually reviewed to develop a more person-centred model and to remove conflicting information that could result in confusion for staff delivering care.

Requires improvement

Is the service well-led?

Our findings

We asked people who used the service or their relatives if they found the service provided at Apple Court Care Home to be well led.

One person stated: “We have new management. They are very open and honest about issues. They care and work hard.”

Upon commencing our inspection we were notified that another regional manager from within Leyton Healthcare had taken over responsibility for Apple Court with support from another colleague. Furthermore, we were informed that following our last inspection, the newly appointed manager had resigned from post in July 2015. We noted that another manager had been appointed in July 2015 who was on annual leave at the time of our inspection. Following completion of our inspection we were notified by email that the new manager was no longer employed at Apple Court.

Two regional managers were present during our inspection. They engaged positively in the inspection process and were keen to help at all times. We observed positive interactions between the management team, people using the service, visitors and staff. We also noted that the management operated an “open door” approach to provide help and support when needed.

We noted that systems were in place to seek feedback from people using the service, their representatives and staff on an annual basis. This process had last been completed during February 2015 and the results had been displayed in a chart in the reception area of the home for people to view. However, there was no written summary of the findings of the survey to accompany the chart, comments from people using the service or an action plan to demonstrate how the service would respond to constructive feedback. The regional manager informed us that this quality assurance system was due to be replaced.

We noted that a business continuity plan had been developed to ensure an appropriate response in the event of a major incident. Additionally we were informed that the organisation’s estates manager was responsible for co-ordinating maintenance and service checks and a refurbishment action plan had been developed.

We checked a number of test records relating to the fire alarm, fire doors, emergency lighting, fire drills and nurse call system and found that checks had been undertaken at regular intervals. Likewise, We sampled a number of service certificates for the fire alarm system, fire extinguishers; hoisting equipment; passenger lifts, gas installation and electrical wiring and found all records to be in order.

The registered person is required to notify the CQC of certain significant events in the home. We noted that the manager kept a record of these notifications. Where the Commission had been notified of safeguarding concerns we were satisfied that the manager had taken the appropriate action. This meant that the registered person was aware of and discharged the legal responsibilities attached to their role.

The local authority continued to monitor Apple Court as part of its contract monitoring function and in response to concerns received about the service prior to our last inspection.

We recommend that the quality assurance system is updated to include a summary report and action plan in response to survey findings to provide a clear audit trail.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The registered person had failed to ensure that the people using the service were protected against the risks of unsafe or inappropriate recruitment practice as some key records had not been obtained.**