Greenwrite Healthcare Limited

Greenwrite Healthcare

Inspection report

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This announced comprehensive inspection was carried out on 15 and 18 October, and 2 November 2018. The provider was given 48 hours' notice as we needed to ensure that key staff were available to participate in the inspection. The inspection activity was completed on 27 November 2018. This was the first inspection of the service since it registered with the Care Quality Commission on 10 October 2017.

Greenwrite Heathcare is a domiciliary care agency which provides the regulated activity of 'personal care' to people living in their own houses and flats in the community. The Care Quality Commission (CQC) only inspects the service being received by people provided with personal care; help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. At the time of the inspection the provider was providing personal care services for five people.

There was a registered manager in post at the time of our inspection, who was present during the inspection. A registered manager is a person who has registered with CQC 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 registered manager is the owner of the service.

We found the provider had not ensured that people were protected from the risk of receiving their care and support from staff who did not have suitable knowledge and experience to carry out their roles. The recruitment practices were not sufficiently detailed and the registered manager had not adequately followed up conflicting information about an employee's background and other discrepancies in references. Although staff had been provided with safeguarding training, the whistle blowing policy did not contain full guidance for staff about how to progress any concerns relating to the conduct of peers or supervisory and managerial staff. The registered manager did not demonstrate a complete understanding of the legal necessity to inform the CQC of any allegations of abuse and neglect.

The member of the care staff we spoke with confirmed they had appropriate access to personal protective equipment to protect people from the risk of cross infection, however one relative reported that this equipment was not always available for staff to protect their family member. Risk assessments were in place to identify and mitigate risks to people's individual safety and the safety of their home environment. The provider had taken action following a serious incident when a person did not receive the care and support they needed to meet their essential needs, due to a communication error by a staff member.

Records showed that staff had received induction, mandatory training and supervision. However, some of these records had been altered with correcting fluid, which was not consistent with record keeping that needs to clearly demonstrate when staff received support from their line manager to understand and achieve the knowledge and skills needed to appropriately meet the needs of people who used the service.

Some of the care and support plans we looked at showed that people's nutritional and health care needs

were met by their relatives. Where people required staff support we found that their care and support plans provided guidance for staff and information about people's preferences. At the time of the inspection we noted that people who used the service had capacity to sign consent forms and agree to the contents of their care and support plans. The design of the consent forms indicated that the provider would not permit a relative to sign on behalf of a person who did not have capacity, unless they had the legal powers to do so. However, relatives and friends could separately sign to evidence that they had been consulted as part of the care planning process.

We received satisfactory comments about the quality of the service and how staff supported a person from the professional representative of one person. However, the relatives of other people told us that they had been alarmed at times by the lack of professional behaviour by staff and the inability of the registered manager to have initially recruited staff with appropriate dispositions, integrity and skills to work with people who used the service. Relatives described how people had not been supported in a dignified way to receive their personal care and how polite and diplomatic boundaries had not been respected by staff within people's homes.

People were provided with information about how to make a complaint and guidance about advocacy services, although further details were required to enable people to choose which advocacy organisation they might wish to approach.

The care and support plans we looked at had been in place for a short time as the provider had begun supporting people in Essex and no longer had local people in the London Borough of Southwark. Therefore, we could not ascertain how the provider reviewed and updated people's care and support plans. Given that some people who used the service had end of life care needs, we would expect that their needs could change quickly due to their diagnosis and frailty.

The provider's own investigations of complaints did not fully explore whether there were shortfalls at the service that had contributed to people not receiving the quality of care and support they should expect.

At the time of the inspection some people were receiving end of life care. We noted that the provider could source bespoke training to support people with specific needs, for example staff could receive external training about how to use specific equipment including enteral feeding apparatus. However, we did not find evidence that staff had end of life care training of a meaningful quality as part of their mandatory training programme.

Relatives expressed that the management of the service was "disorganised" and "chaotic." This partly stemmed from the distance that some care staff travelled to reach people in Essex, which concerned relatives as it sometimes impacted on punctuality when difficult travel conditions were beyond the control of members of the care staff. The registered manager informed us that she was recruiting more staff in the Chelmsford area and monitoring when it could be necessary to apply to CQC to open a new location in the area, so that care staff could have better systems of local support.

Information published on the provider's website did not provide current information about how they met the needs of people who used the service.

We saw that spot checks were being carried out, however relatives reported that the standards of care fell below their minimum expectations. The quality of care and support and the type of concerns we heard about the service demonstrated that the provider's own quality monitoring systems were not identifying and addressing problems at the service.

We have made one recommendation that the provider seeks guidance to improve the quality of recording on people's medicine administration records (MAR) charts. We have issued three breaches of regulation in relation to the provider not ensuring the safe recruitment of staff, the failure to notify the CQC of any allegations of abuse in line with the law and the provider's lack of robust monitoring to detect and address issues of concern that impacted on the quality of care and support for people who used the service.

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 always safe.

Staff recruitment practices were not sufficiently detailed to ensure that staff were suitable for the roles and responsibilities.

Staff were provided with safeguarding training. However, the registered manager had not complied with informing CQC about safeguarding alerts, in line with legislation.

The whistle blowing guidance for staff was incomplete.

Improvements were needed for recording medicines and ensuring people were protected from the risk of cross infection.

Is the service effective?

Requires Improvement

The service was not always effective.

People's needs were assessed before they received a care package.

The documentation for staff induction, training and supervision did not demonstrate that staff received a timely, structured and beneficial level of support from the provider.

People were provided with support to meet their nutritional and health care needs where required, although we received information of concern from the relative of a person who needed support with eating and drinking.

The provider sought people's consent for staff to provide support with their personal care.

Is the service caring?

Requires Improvement

The service was not always caring.

Mixed views were expressed about whether people received kind and compassionate care. Where relatives recognised that some individual care workers had been thoughtful and reliable, the quality of their family member's care had been negatively

impacted on by the disorganised way the service was managed.

Information was provided about advocacy services but needed further details.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The care and support plans were adequately written to state people's needs and wishes.

The provider's own investigation and analysis of complaints did not acknowledge fundamental shortfalls in how the service was operated.

Staff did not have a comprehensive level of training to understand and meet the needs of people with end of life care needs, including training to communicate empathetically with people's relatives and friends.

Is the service well-led?

Requires Improvement

The service was not always well-led.

We received negative comments from relatives about how the service was managed.

The provider's website and an online review did not reassure people who used the service of a transparent and professional approach.

The registered manager's own quality monitoring had not picked up on the range of issues of concern detected by people who used the service, their representatives, and health and social care professionals who had investigated safeguarding alerts and quality alerts.

Greenwrite 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.

This was the first comprehensive inspection of Greenwrite Healthcare since its registration with the Care Quality Commission (CQC) on 10 October 2017, and was carried out by one adult social care inspector. The provider was given two days' notice of our plan to conduct this inspection because we needed to ensure that the registered manager or a senior person was available. Prior to the inspection we received information of concern from an anonymous source in relation to the quality of care and support for people who used the service, and the provider's standards of recruitment, induction and training for staff. This announced inspection was undertaken on 15 and 18 October 2018, and we returned to the provider's office on 2 November 2018 to complete the inspection visit and provide feedback. Following this visit we were contacted by the relatives of two people who had used the service who wished to share their views about Greenwrite Healthcare. Therefore, our inspection activity concluded on 27 November 2018.

Prior to the inspection we reviewed the information we held about the service and any notifications we had received. A notification is information about important events which the provider is required to send to us in line with legislation.

During the inspection we spoke with the registered manager and looked at a range of documents which included four care and support plans, the complaints log, four staff files to check recruitment, training and supervision, two medicine administration record (MAR) charts, policies and procedures, and safeguarding records.

We spoke by telephone with the relatives of three people and a professional representative of a fourth person. We also received information from a health and social care professional employed in a commissioning role. We attempted to contact four care workers but received comments from only one.

Requires Improvement

Is the service safe?

Our findings

Recruitment processes were not sufficiently rigorous to ensure that people who used the service received their care and support from staff with suitable knowledge and experience to safely meet people's needs and wishes. The staff files we looked at contained two references, proof of identity, proof of eligibility to work in the UK and a Disclosure and Barring Service (DBS) check. The DBS provides criminal record checks and barring functions to assist employers to make safer recruitment decisions. However, the registered manager had not appropriately scrutinised the documents she received to ascertain whether they were satisfactory or whether additional clarifications were necessary. For example, one staff file showed that the information an employee supplied to the registered manager about a criminal conviction did not match the extent of the information recorded on the DBS. There was no written evidence to demonstrate that the registered manager had sought an explanation from the employee to explain this discrepancy. One of the references was from a referee stated to be the staff member's lecturer but there was no letterhead or company stamp to evidence where the lecturer was employed. This had not been followed up by the registered manager. Another staff file had two very similarly worded references from a supervisor and a manager at the same company. There was no evidence to show that the registered manager had contacted the company to check the validity of the references and discuss if there were any acceptable reasons why the references were so alike. A third staff file showed that a staff member had recently worked for five years in a professional environment for children, however they had two personal references from referees not connected to their employment. We discussed this finding with the registered manager who told us the staff member's former employer refused to give a reference. There was no evidence to demonstrate that the registered manager had sought an additional reference from an individual or organisation that could comment on the employee's conduct.

We noted that during the inspection the registered manager contacted members of the staff team and referees to rectify these shortfalls. However, these findings were a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered manager had not identified and addressed these concerns when she carried out staff recruitment.

We received mixed views from the relatives and a professional representative we spoke with in relation to whether people received a safely delivered service. The professional representative told us the person was pleased with their care and support. The provider was stated to have succeeded in working well with the person, who had reported difficulties when using several other domiciliary care agencies. Relatives told us that they had not experienced missed visits but some had encountered periodic issues with staff punctuality, particularly where staff were travelling to Chelmsford from London. One relative told us about an injury that their family member had while being looked after by care staff, which resulted in an unexplained cut on their face. The relative had informed the community nurses and a safeguarding alert was raised. The relative also told us they made a complaint to the provider as their family member was assessed to require 'double handed' care from two care workers but only one care worker turned up, and this had happened frequently. Other relatives reported that 'double handed' care was delivered in line with people's assessed needs, although we noted that a complaint for earlier this year for a person who no longer used the service had raised concerns about only one care worker turning up instead of two.

Records showed that staff had received safeguarding training and the one staff member we spoke with presented a comprehensive understanding of how to recognise the signs of abuse. The staff member told us they would take any possible immediate action to ensure the person was safe and contact their line manager to report their concerns. The provider's safeguarding policy stated that the provider needed to inform the local authority of any safeguarding concerns and notify the Care Quality Commission (CQC). However, the registered manager failed to inform CQC without delay when there were two allegations of neglect. This demonstrated that the provider did not comply with the legal requirement to inform the CQC of safeguarding concerns to enable us to monitor safety at the service and take appropriate action where needed. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The whistleblowing policy did not contain adequate guidance for staff about how to whistle blow. Whistleblowing is when a worker reports suspected wrongdoing at work. The policy advised staff to inform their supervisor or the registered manager if they had any concerns, but did not offer additional advice to staff if their concerns were about the conduct of their supervisor and the registered manager. We discussed this finding with the registered manager who told us that an updated version of the whistleblowing policy was due to be printed in new staff handbooks. The staff member we spoke with was aware of how to whistle blow within the company and to relevant external bodies.

Individual risk assessments and environmental risk assessments had been undertaken to recognise risks to the safety and wellbeing of people who used the service. The risk assessments we looked at contained an adequate level of guidance for staff to follow to mitigate the identified risks. We noted that the provider carried out Waterlow risk assessments, which is a tissue viability assessment tool that provides an estimated risk for the development of a pressure ulcer in a person. The Waterlow recorded they had dry but unbroken skin, however the care and support plan for one person stated they had two pressure ulcers which were being treated by district nurses.

Staff had received training in relation to how to safely administer medicines and their care plans explained if they managed their own medicines, were supported by their relatives, or required prompting or other assistance. At the time of the inspection two people who used the service required support from care staff to meet their prescribed medicine needs. The medicine administration record (MAR) charts we looked at had occasional unexplained gaps where we could not determine if the person had received their medicines. Staff ticked that they had prompted or administered medicines which meant that there was not a clear audit trail, particularly where two care staff attended for 'double handed' care. We found the design of the MAR charts difficult to understand, which we discussed with the registered manager.

We recommend the provider seeks guidance from the Royal Pharmaceutical Society published document for adult social services in relation to the safe completion of MAR charts.

Records showed that staff had received infection control training and the staff member we spoke with stated they were provided with personal protective equipment, for example disposable gloves and aprons. A relative with a background as a retired nursing professional informed us they had witnessed unacceptable standards of infection control practices at the home of their family member. This included staff not having access to disposable gloves and aprons, and staff inappropriately using a kitchen tea towel for supporting their family member with their personal care needs.

We noted that the registered manager had reported to the commissioning team when a person who used the service had a fall, which was required by the commissioning team. We saw an example of how the registered manager had made changes to the 'no response' policy following a serious communication error by the provider which resulted in a person not receiving personal care visits, which included support with

eating and drinking, continence care and taking medicines for two days.

Requires Improvement

Is the service effective?

Our findings

The care and support plans we looked at demonstrated that people's needs were assessed by the provider before their care packages commenced. However, one relative told us that a care and support plan was not delivered to their family member's home until several days after the provider began delivering the care package. The assessments sought information from people and their relatives about the interests, preferences and routines, as well as their personal care needs.

Records showed that staff had received induction training and they shadowed experienced staff before undertaking any visits on their own. Prior to the inspection we had been informed by an anonymous source that these records were not an accurate account of how the provider delivered induction training. We spoke with the registered manager about the frequent use of correcting fluid on various records we looked at, which included induction, training portfolios and one to one supervision for staff. We saw one example for a staff shadowing record where the name of a member of staff had been covered with correcting fluid and another name written over. The registered manager told us they used correcting fluid to save time when they made a mistake. However, this regular use of correcting fluid did not promote a suitable standard of transparency and professional record keeping to evidence how the provider ensured that staff were trained and supported to effectively meet the needs of people who used the service.

The training records demonstrated that staff were provided with mandatory training, for example health and safety, food hygiene, medicines, safeguarding and infection control. Although some of the training was online, other training including moving and handling was provided by an external trainer in a classroom setting. At the time of the inspection the provider was receiving care packages in Essex for people with end of life care needs. The registered manager told us the trainer was a registered nurse and provided other staff training as required to meet people's individual needs, for example training to support people with PEG (percutaneous endoscopic gastrostomy) feeding. This is a when a tube has been passed into a person's stomach during a medical procedure, most commonly to provide a mean of feeding when oral intake is not adequate.

It was difficult to track the frequency of care staff receiving one to one supervision, due to recent and rapid changes in staffing. We saw that one staff member had supervisions in February and March 2018 but nothing since. We found a supervision record with no date on it. A second staff member had almost identical supervisions 10 days apart in May 2018. A third member of staff had supervision in October 2018 but the supervisor had signed that the session took place in June 2018. Another member of staff was asked the same questions at their supervision sessions in July and August 2018 and gave almost identical answers. These findings questioned the value and reliability of the provider's formal staff supervision.

Where people who used the service needed support to meet their nutritional needs, the information about how care staff should assist them with eating and drinking was satisfactorily written. However, a relative told us they had turned up at their family member's home on two occasions to find care staff had not positioned a jug of water in a location that their family member could help themselves to. Their family member had also reported that they were hungry, although care staff should have supported the person with eating and

drinking.

The professional representative for one person who used the service had received positive comments about how staff supported the person. We were informed that as the provider had developed a good relationship with the person and was able to meet their needs in a way that other providers had not been able to achieve, the local social services planned to approve the provider as the person's permanent domiciliary agency. The registered manager told us that the care staff primarily worked with district nurses and she felt that positive relationships had been established. The health and social care professional we spoke with at the commissioning team informed us that there had not been any significant known concerns about the quality of care and support but recently they had received information of concern from the relative of a person who used the service, which they were investigating.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The care and support plans we looked at showed that people were supported to sign their own care plan if they had the capacity to do so. Three out of the four care plans we looked at had been signed by people and other information within their plans confirmed they had been consulted about how they wished their care and support to be provided. The design of the provider's consent form meant that the agency would not ask relatives or friends to sign on people's behalf unless they demonstrated they had the correct legal authority to do so. The one member of staff we spoke with explained how they would speak with people about their personal care to ensure people were agreed for them to proceed.

Requires Improvement

Is the service caring?

Our findings

The comments we received from the relatives of people were not positive. The relative of one person who used the service told us they had ceased using the agency because of the disappointing conduct of the staff and the registered manager. The relative told us that their family member required the support of two members of the care staff for personal care but only one staff member consistently turned up. Their family member and another relative who lived in the household did not initially report that only one care worker was turning up as they were happy with the approach of the regular care worker and did not want to possibly jeopardise this stability. However, the regular care worker did not report the failure of his colleague to turn up to the provider, which placed the person who used the service at risk of injury as they were not being supported in line with their assessed needs. The provider sent a supervisor to the person's home when they received the complaint, however the supervisor shocked the person who used the service and their relatives by using racist language and speaking about people in an offensive manner. The supervisor also asked the regular care worker if they could find any new care staff at their church because the provider was having difficulty in recruiting employees. This conversation took place in front of the person who used the service and their relatives, which led to a loss of confidence and trust in the provider's ability to reliably provide an adequate service. The registered manager informed us the supervisor was from an employment agency and was no longer used after she was alerted to these concerns. The relative reported that they continued to use the service after this experience but eventually reached a point when it was no longer tenable to do so. The relative stated that after care staff had completed their family member's care they sometimes sat in a car outside the house for long periods. The relative suspected that this was because the provider is based in London and perhaps the staff were not local and had nowhere else to go between visits. However, the family found this unsettling as it impacted on their ability to relax between visits and they were never consulted by staff about whether this practice could have caused concerns for their neighbours.

Another relative told us that management of the service was chaotic but they got to know the individual care staff who were providing end of life care for their family member in their final days, and did not have any complaints about the conduct of these care staff.

A third relative had also ceased using the service as they were unhappy with the quality of care and the approach of the care staff, which they did not find caring or compassionate. The relative told us they discovered that their family member had not been appropriately supported with personal care, for example changing into clean night clothes or being supported to have a shave. The relative found that the care staff did not always provide their family member with privacy and dignity.

It was difficult to ascertain whether some people who used the service and their relatives had experienced care that was respectful and compassionate. This was because sometimes people used the service for a short time only due to their end of life care needs and their relatives might not have completed a survey or shared their views with the provider. We telephoned a person who used the service for their views and learnt from a care worker that the person had passed away earlier that day. The care worker sounded genuinely upset and had remained with the family to help with any chores, having checked with the registered manager for guidance. The bereaved family member of the person asked the provider to take over their care

package as they had been pleased with how the provider had looked after their relative.

We noted that the provider's booklet for people and their representatives contained details of the contact numbers and addresses of advocacy organisations but did not give the names of the organisations. Advocates can offer independent support to people to assist them to express their views and wishes, and also support a person to make a complaint about the standard of their care from the provider or any other organisations providing them with health and/or social care services. We pointed out this oversight to the registered manager who confirmed that she would rectify this.

Requires Improvement

Is the service responsive?

Our findings

The care and support plans we looked at had been written by the registered manager. They were not unduly brief and attempted to explain how people wished to be cared for in line with their individual needs and preferences. As the people who used the service had been with the provider for short periods of time, we did not find evidence of reviews having taken place. However, as some people were receiving end of life care it would be anticipated that their needs could rapidly change, for example a person who was mobile could become bedbound in a short period of time. The provider carried out monitoring visits which would enable the registered manager or a supervisor to check whether people's needs had changed. Where we saw daily records completed by care staff, their entries were consistent with the person's needs as described in their care and support plan.

We noted the provider had attained a significant number of concerns and complaints from people who used the service and/or their relatives, taking into account that the service had been operative for less than a year at the time of the inspection. Two of the relatives we spoke with stated they had complaints about the quality of the service and were pleased to no longer be using the provider. The registered manager had carried out their own complaints investigations but these were not always as thorough as required, as they did not identify the provider's own shortfalls. For example, a relative had complained that staff had not safely supported their family member to mobilise which had resulted in the person having a fall. The registered manager's investigation had indicated that the fall took place before care staff arrived at the person's home. However, the local authority social worker had found that the registered manager had not ensured that care staff had a file with daily record sheets maintained in the person's home, which meant the service did not have accurate records to confirm the times and duration of their visits.

The provider was providing end of life care for people at the time of the inspection. People who were receiving end of life care were also being supported by district nurses and other health care professionals, for example one relative told us they could seek advice from a hospice outreach nurse. The staff training files we looked at did not evidence that staff had end of life care training and although the provider stated that they could arrange externally delivered bespoke training staff as required, for example PEG (percutaneous endoscopic gastrostomy) feeding, the registered manager had not recognised the lack of a dedicated end of life course for employees as being a shortfall in the provider's staff training and development plan. The registered manager told us that the training she could access for PEG feeds and any other apparatus that care staff might be required to use would meet people's end of life care needs. However, this did not take recognise that care staff also needed to understand how to meet people's emotional needs.

Requires Improvement

Is the service well-led?

Our findings

The registered manager informed us that although the service was registered in October 2017, the service did not commence care and support for its first person until January 2018. The service is situated in the London Borough of Southwark and the local authority brokerage team referred approximately eight people in the early part of 2018. Their care packages were funded by the local authority and these people's care and support were subsequently withdrawn from the provider. The documentation shown to us by the registered manager indicated that the local authority withdrew at least three of the care packages due to safeguarding concerns, quality issues and complaints from people who used the service and/or their representatives. The registered manager had recruited local staff when the agency provided services for local people, however at the time of the inspection the provider was supporting people who lived in the Chelmsford area. Therefore, the care staff allocated to provide care and support for people were mainly agency staff, although the plan was for these agency staff to join the staff team at Greenwrite Healthcare. We saw minutes to demonstrate that care staff attended monthly meetings with the registered manager and discussions took place in relation to areas for improvement and complaints. However, staff had not previously been asked to sign a register when they attended a staff meeting but the register had commenced in October 2018.
We received one comment from a professional representative for a person who used the service, who stated the provider had worked well with the person and had supported them to accept a care package. The relative of a person who used the service told us, "My overall experience of this company is that they are a 'Mickey Mouse' organisation providing basic poor care." The relative's observations of the staff included an allegation of the falsification of daily records in relation to the time they arrived and left the family member's home. Other relatives commented on a chaotically organised service, managed by a registered manager who did not display the expected standard of professionalism. Our findings during the inspection indicated that there were specific recurring themes of concern. We noted that a concern had also arisen about staff falsifying the daily records for a person who formerly used the service in the London Borough of Southwark.

A relative had also noted that there were negative and unprofessional online reviews about the provider, which did not offer reassurance about the quality of the service. This included one complimentary positive review about the management of the service allegedly written by the registered manager herself. We acknowledge that this was likely to be an act of sabotage posted by a third party, however its visible presence was concerning for people who used the service and their representatives. We would advise that the registered manager should check for any false reviews so that any such reviews can be deleted where required, to protect the integrity of the service.

During the inspection we spoke with the registered manager about the office they had established in Essex. The registered manager had obtained guidance from the Care Quality Commission to assist her to determine whether the new office needed to be registered as a location. The registered manager's description of how the office was used was consistent with a branch office for the storage of gloves, aprons and some administrative purposes, as opposed to a location where care and support plans were stored.

The anonymous information we received indicated that former employees were concerned about alleged unacceptable practices at the service. We were not able to establish why there was a noticeably low

response to the messages we left for care staff to contact us to discuss their experiences of working for the service.

The provider's vision and aims were shared on its website, "Greenwrite Healthcare is a nationwide domiciliary care organisation that prides itself in allowing individuals to live life the way you choose." The website did not focus on the current provision of end of life care but described the care of people living with dementia as being one of the specialised areas, "Our experienced and highly trained caregivers provide the highest quality of care to both patients and their families." We did not find any evidence at the time of the inspection of staff having undertaken any specific training in dementia care, for example training with the Alzheimers' Society or City and Guilds qualifications and the provider did not evidence active links with the local dementia care organisations.

The complaints raised by people who used the service and their relatives, and the issues of concern found when placing authorities investigated safeguarding alerts and complaints showed that the provider's own monitoring systems were not sufficiently robust to identify unsatisfactory standards of care and support. The provider failed to make sure there were effective systems and processes to assess, monitor and improve the quality of care provided by the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 person did not notify the Care Quality Commission of allegations of abuse. 18

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality checking arrangements did not consistently assess, improve, monitor and sustain the quality of experience for people who used the service. 17(1)(2)(a)(b)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provided did not establish and operate effective recruitment procedures. 19(2)