Springwood Healthcare Services Ltd

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Springwood Healthcare Services Ltd is a homecare agency based in the London Borough of Barnet. At the time of this announced inspection, they were providing care and support to at least 10 people living in their own homes, primarily in the London Borough of Harrow. They were not providing any nursing care. The service's stated specialisms include providing care to people with a learning or physical disability or those with a mental health condition.

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

At our previous inspection of this service, in June 2016, breaches of legal requirements were found. These were in respect of staff recruitment processes and accurate record-keeping. At this inspection, we found these matters had not been sufficiently addressed. We also identified new breaches of regulations.

Recruitment procedures were still not ensuring that staff were safe to work with people using the service before they started providing care. One staff member was found to have provided care to people before any recruitment checks were undertaken. Their criminal record (DBS) check subsequently showed some information that the provider needed to risk assess in respect of making an employment decision. However, the provider did not do that until we brought the matter to their attention. This meant that for over seven months, the provider had sent somebody to provide care who may not have been safe to work in people's homes. Procedures were also not robust at acquiring all appropriate written references for new staff.

There continued to be cases where records were inaccurate or incomplete, despite some improvements in this area. In particular, there were a number of inaccuracies within records of the support staff provided people to take prescribed medicines, meaning people may not have been supported to take their medicines as prescribed.

There was mixed feedback about care visits occurring punctually. A system for agreeing visit times with individuals had not been embedded. Some people consequently experienced occasions when staff did not attend as planned, which failed to ensure care needs were met and put some people at avoidable risk to their health and welfare.

Complaints were not identified, recorded, handled and responded to effectively, despite prompt and apologetic replies. Complaint investigations were not robust. Complainants were not provided with options if they were dissatisfied with responses.

Governance processes were not effective at identifying risks to the delivery of high quality care, as demonstrated by our findings in respect of medicines, visit punctuality, complaints handling and record-

keeping. This was despite some improvements in quality auditing processes, particularly around staff support and supervision structures.

We found the provider not to be consistently open and honest with us. This was primarily due to not declaring the names of everyone using the service and all care staff when we requested the information before the inspection. This undermined the inspection process.

Most people and their relatives said they would recommend the service. We found people were treated with respect and their dignity was promoted. People received the same small team of staff for their care, and were supported to be involved in making care decisions. Care plans were promptly set up, based around assessments of needs, preferences and risks. The service provided support for people's health and nutritional needs where appropriate.

Staff training had improved since our last inspection. A training room had been added to the office structure. It contained various items by which to train staff. The registered manager told us she now did much of this herself, as she had completed courses to help her to do so. Staff were also completing a national training process called The Care Certificate, which helped demonstrate appropriate knowledge for their care roles.

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

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. There were enough staff, but they were not deployed in a way that consistently kept people safe and met their needs. Additionally, robust recruitment checks were not completed before employing staff and sending them to provide care to people in their own homes.

There were a number of inaccuracies within records of the support staff provided people to take prescribed medicines, meaning people may not have been supported to take their medicines as prescribed.

The service had systems for assessing risks to people's safety and taking action where needed, and for protecting people from abuse.

Is the service effective?

Good

The service was effective. Staff had the knowledge and skills necessary for their care roles.

The service provided support for people's health and nutritional needs where appropriate.

The service was working within the principles of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring. People were treated with respect and their dignity was promoted.

The service supported people to express their views and be involved in making care decisions.

The provider tried to enable positive and caring relationships to develop between staff and people using the service.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. There was mixed feedback about visits occurring on time, and a system for

agreeing visit times had not been embedded. Some people consequently experienced occasions when staff did not attend as planned, which failed to ensure care needs were met.

Complaints were not identified, recorded, handled and responded to effectively, despite prompt and apologetic replies.

Care plans were promptly set up to help ensure people's needs and preferences were met.

Is the service well-led?

Inadequate

The service was not well-led. Governance processes were not effective at identifying risks to the delivery of high quality care, as demonstrated by the breaches of regulations we found. This was despite some improvements in quality auditing processes.

There continued to be cases where records were inaccurate or incomplete, despite some improvements in this area.

We found the provider not to be consistently open and honest with us, primarily due to failing to declare the names of everyone using the service and all care staff when we requested the information before the inspection.

Springwood Healthcare Services Ltd

Detailed findings

Background to this inspection

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

This was an announced inspection and took place on 28 July 2017. We gave the provider 48 hours' notice of the inspection because of its smaller size and as the registered manager can be out of the office supporting staff or providing care. We needed to be sure that they would be available.

The provider completed a Provider Information Return (PIR) in advance of the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

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

The inspection was carried out by one inspector and an Expert by Experience, which is a person who has personal experience of using or caring for someone who uses this type of care service. Their involvement was limited to phoning people using the service and their relatives to ask them their views of the service.

There were at least 10 people using the service for personal care support at the time of our inspection. During the inspection, we received feedback about the service from one person using it, six people's relatives, and two community health and social care professionals. We also spoke with, three care staff, an office staff member, and the registered manager.

During our visit to the office premises we looked at four care plans for people using the service plus other records about people's care including visit schedules, medicines records and care delivery records. We looked at the personnel files of five staff members and records about the management of the service such as complaint records, incident records and visit plans. We were also provided with, on request, further specific information about the management of the service from the registered manager following our visits. This included specific policies and evidence of actions taken to address specific concerns.

Inadequate

Is the service safe?

Our findings

At our last inspection, we found recruitment procedures were not ensuring that staff were safe to work with people using the service. This meant the provider was in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found the provider was still not ensuring safe recruitment practices. This was despite sending us an action plan outlining improvements they would make in respect of our previous concerns.

One staff member was found to have provided care to people in December 2016. This was before recruitment checks on them, including written references, identification checks and a recruitment interview, had been completed. The criminal record (DBS) check on file for them was received almost two months later. It showed some information that the provider needed to risk assess before making an employment decision. However, the provider did not do that until we brought the matter to their attention. This meant that for over seven months, the provider had sent somebody to provide care who may not have been safe to work in people's homes. This demonstrated a failure to ensure good character before employment.

Robust recruitment checks had not taken place for another staff member. Records showed they had provided care to someone two days before the date of their DBS check on file. Their application form showed no employment for the previous five years but there was no record made of explaining the employment gap. One of their written references was from an employer without stating when the employment occurred. There was no record of exploring that potential discrepancy in what the staff member had declared for their employment history.

During the course of the inspection visit, we became aware of staff who had provided care to people recently but who had not been declared on the list of staff the provider sent at our request shortly before the inspection. One such staff member had a recent employment history that included care work. However, reasonable efforts had not been made to acquire written references from the two previous care employers. This meant the provider did not have satisfactory evidence of the staff member's conduct in those two care employments, and so had not taken all reasonable steps to ensure the staff member was safe to provide care in people's homes.

The provider's recruitment policy did not specify that written references were required from previous care employers as per care regulations. It also failed to state what would happen if an applicant's DBS disclosure had information on it. The policy was not therefore sufficiently robust at ensuring all appropriate recruitment checks occurred before employment decisions were made.

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

The registered manager told us they now asked for CVs following employment histories not being filled in during staff applications. We also noted the good practice of documenting phone calls to referees, in

addition to receiving written references, before job offers were made.

The service supported people to take medicines where needed. Staff we spoke with knew to sign their initials on the medicines administration record (MAR), to contact the office if people were refusing medicines, and that only trained staff were allowed to support people with medicines. Records showed appropriate risk assessments and care plans for medicines support. Senior staff undertook competency checks of staff at each person's home before they provided medicines support alone.

However, we found medicines records were not consistently completed accurately, as there were errors of the records of the two people we checked on. One person's MAR for May 2017 had just codes entered without staff initials. The codes indicated either the person had taken the medicine already, or staff gave the medicine to the person to take. The MAR contained occasional administration gaps on three days without explanation. It did not contain reference to a short-term antibiotic that the registered manager recorded as giving the person on the care delivery record. This omission put the person at risk of not being supported with taking the short-term medicine at subsequent care visits.

The MAR also showed one medicine being given or taken in the evening for the first nine days of the month before the codes were crossed out. The medicine profile indicated once daily, which had occurred in the morning, but at twice the dose than on the MAR. Another medicine was not recorded as taken for the first ten days of the month despite being listed on the medicines profile for taking twice daily. The MAR stated once daily. There was a risk the person was not being supported to take their medicines as prescribed.

The same person's March MAR showed staff signing the MAR for days and times when they were not present, as care visits were only to occur on certain days. This did not include weekends, but medicines were signed for across two of the four weekends of the month. This demonstrated inaccurate records of the support the person had with medicines.

Another person's MAR failed to document what happened to medicines support on the last two days of April 2017, although their care delivery records on those days made some reference to medicines support being provided.

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

Most people and their relatives told us there had not been any recent occasions when staff did not turn up at all. Two people spoke of this having occurred in the past. However, one relative told us of a missed visit "only this week. Someone never turned up in the evening one. I had to tell them and she apologized."

Due to hoisting and associated support, one person needed two staff to attend together to meet their care needs. The registered manager told us the first staff member waited for the second to arrive, so that they both attended to the person together. However, the person's care records showed five occasions when only one staff member was recorded as attending in the three months before our visit. On one occasion, the records stated the person was hoisted by only one member of staff, which put them at undue safety risk. A social worker emailed about a different occasion of only one staff member attending, six weeks before our inspection visit. The management team's reply stated that the second staff member was running late. This demonstrates occasions of failing to provide the person with care that was appropriate and met their needs.

Records showed another person was having one staff visit on certain mornings of the week. However, on

two mornings, in March and May 2017, there was no record of the planned visit in their care delivery records. We emailed the registered manager about these care record omissions indicating staff not visiting as planned, but no explanation was provided.

We concluded the service had enough staff, but they were not deployed in a way that consistently kept people safe and met their needs.

The evidence above contributes to a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us the service was safe. One relative described their usual staff member as "trustworthy." Another told us, "They make sure she doesn't get hurt." A third person said, "They lock the front door when they go out." Feedback and records indicated that there were enough staff working at the service.

Staff told us they phoned the office if they identified safety concerns such as if people did not let them in for planned care visits. They confirmed they had identification badges which they showed people at the start of visits. Some people we spoke with confirmed staff showed identification badges and one person told us of staff having the company uniform.

A broad range of risks were documented as assessed in people's homes at the start of care packages being delivered. This included risks for the care environment, falls, skin care, choking risk, moving and handling, and medicines management. However, the assessments did not consistently identify what action would take place in respect of any risks identified such as for one person's pets. Other records indicated that some action took place, such as with liaising with community healthcare professionals where risks were apparent. Therefore, the risk assessment documentation lacked a degree of accuracy and completeness about what the key risks were, what plans were made to address risks, and reviewing matters to ensure actions were taken.

The provider had an extensive safeguarding policy in place by which to ensure people were protected from abuse. Records showed staff were trained on safeguarding. The registered manager showed us the online memos sent to all staff about good safeguarding practices. Staff could provide examples of signs of abuse, and knew how to raise safeguarding concerns. The registered manager told us there had been one safeguarding investigation relating to the service since our last inspection. They talked us through the actions taken in response to the findings. This included further training for individual staff involved, and the hiring of a consultant to provide additional and independent staff supervision. We saw evidence of this occurring.

Good

Is the service effective?

Our findings

At our last inspection, we found training did not ensure that staff had the knowledge and skills needed for their roles. Additionally, the provider was not ensuring that all relevant aspects of The Mental Capacity Act 2005 were being implemented. This meant the service was not consistently effective.

At this inspection, we found the training provided to staff had improved. Since our last visit, a training room had been added to the office structure. It had a number of resources including a hospital bed, a mobile hoist, catheters, medicines dispensing devices and a resuscitation dummy. The registered manager showed us recent certificates of being trained to provide manual handling training through a two-day course, and also for general staff training through an online course. The registered manager explained that she could now provide new staff with much of the training they needed whenever they started, as well as providing established staff with refresher training.

The registered manager told us new staff were provided with four to five days of office-based training, which staff induction records confirmed. Staff then worked with experienced staff at their care visits as additional staff before working alone. There were workbooks of new staff completing a national training process called The Care Certificate within their first three months, which helped demonstrate these staff had appropriate knowledge for their care roles. Staff confirmed this occurred, and that they found the training helpful.

Staff supervision sessions were taking place approximately every other month. Records showed they covered a range of topics around staff support and development, and ensuring staff had the skills for their care roles. Staff confirmed these occurred and were useful. This helped ensure that staff had the knowledge and skills necessary for their roles.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We found the service to be working within the principles of the MCA. The registered manager told us no-one had Lasting Power of Attorney arrangements. Staff were now attending basic training on how the MCA should be used in their work with people. The registered manager was now assessing people's capacity to consent to care and treatment when setting up the care package, and people were asked to sign consent both to care in general and specifically medicines management.

People and their relatives told us the service was effective. Comments included, "The care has changed my life and my mum's life; she is doing much better" and "They look after my mum well, we're just happy." Most people said they would recommend the service.

The service provided support for people's health and nutritional needs where appropriate. A relative told us, "If something is wrong they normally point it out. Her legs were swollen so <the staff member> said it was advisable to ring the doctor." Another relative said, "They try in the nicest way to get her to eat." A third relative told us of staff supporting the person to follow physiotherapy exercises, adding "She helps my mum to try and make her walk around the house and try to climb a couple of stairs."

The registered manager told us one person came out of hospital with a pressure ulcer. Records and feedback showed the support provided by the service, including through acquiring community healthcare professional support and good hygiene practices, had helped to eradicate the ulcer. Records showed the registered manager, a registered nurse, provided staff with training sessions on specific healthcare matters such as pressure ulcer prevention and diabetes care, earlier in the year. Staff meeting minutes included reminders about preventative health measures such as reporting reddened skin so that action could be quickly taken by contacting community healthcare professionals.

Care assessment records considered people's specific health and nutritional needs, including for continence, skin integrity, sensory impairments, dietary restrictions and what specific equipment was being used. Elements of this were incorporated into care plans such as someone's specific foot care needs and what food people preferred.

Good

Is the service caring?

Our findings

People and their relatives told us the service was caring. Comments include, "They seem more caring (than others)", that the visiting staff member "always says hello and smiles and my mum is happy" and "Even if he is irritated they are calm." One relative said, "They're very nice, they speak to my mum and they've learnt a few Gujarati words. They laugh with my mother."

Staff told us the registered manager provided training on dignity and respect. They gave examples of how this was implemented, such as with closing doors during care, enabling choice and independence, "not being rude", and helping people to feel important. The provider told us of having a Dignity Champion commitment.

The management team told us if staff were running late, they were required to contact the office who then informed the person due to be visited or their relatives. Staff confirmed they did this. People and their relatives told they were mostly kept informed if visits were running late. This demonstrated respect by keeping people informed.

Standards of care were written into staff job descriptions such as for privacy, dignity and confidentiality matters. Records showed this was considered as part of staff employment interviews. The caring nature of staff was also reviewed during unannounced visits by senior staff to check on people's care.

People and their relatives told us of usually having the same small team of care staff for visits. One relative said, "We sort of have regular carers. They learn what they need to look after my mother." Visit records tended to show the same staff providing care to individuals. A staff member told us, "Good relationships with clients" was a strength of the service. This meant getting to know the person's preferences such as "what they liked to eat and what they liked to talk about." This indicated the provider tried to enable positive and caring relationships to develop between staff and people using the service.

Some people and their relatives told us of being introduced to new staff by familiar staff or the registered manager. For example, one relative said, "I think what happens they come with the known staff and then they introduce us to her." This process helped staff get to know people's needs and preferences.

The service supported people to express their views and be involved in making care decisions. People and their relatives told us they were listened to. Comments included, "They make sure that she has what she wants and everything; they're here for her" and "If my mum has an opinion then they will listen." The needs assessments at the start of care packages documented the involvement of people and their relatives, which helped identify needs and preferences. There were questions about people's life histories, which enabled communication between the person and staff.

Relatives told us of the service supporting people with independence where appropriate. Comments included, "They prompt him a lot and he does what he can" and "They are encouraging to do things herself, like raising her legs on the foot stool by herself." Care plans guided staff on promoting independence.

Requires Improvement

Is the service responsive?

Our findings

People had mixed views on how punctual visits were. Whilst there were some positive views expressed, one person told us of visits often being late, up to 55 minutes later than planned. They said this delayed them getting important medicines, food and drink and left them feeling "very weak." Someone's relative said, "Time keeping is a big weakness especially on the weekend. If you come at three for lunch when you're supposed to be here at one, it's hard to feed her when you come again at four." Another relative told us of morning visits sometimes being 30 to 45 minutes late. A staff member also told us that visits had been late to one person.

One person's care plan stated for support with personal care and breakfast, and to prompt them to take medicines. However, care visit records showed that they had already washed and dressed themselves by the time of visits at 11:00, 11:30 and 10:40 during one week in May 2017. There were records of a complaint about one of these visits being too late and hence medicines not being given. 08:30 was stated as an appropriate visit time. This shows failures to ensure the person's care met their needs.

We noted people's care files did not record what time they preferred visits to occur at. The registered manager said this depended on what the social worker stated; however, such paperwork in people's file often gave no specific time. By not clarifying and documenting what time preferences the person wanted, misunderstandings could occur and complaints could be made that were avoidable.

The visit plan for one person stated they were to receive a visit from 11:00 to 12:20 on one day, which was three hours later than their usual first visit of the day. The registered manager explained the person "wanted a lie in and requested a late morning call. We try to be flexible with our service users as we are dealing with people with constantly changing needs." However, there was no subsequent flexibility about the lunch visit which overlapped the belated morning visit by 20 minutes. Another relative informed us, "If she has to go to the hospital in the morning then she won't get her morning call and it's difficult for them to come earlier." This did not demonstrate a flexible service.

The evidence above contributes to a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives know how to raise concerns about the service, mainly by approaching the registered manager. One relative told us, "It's happened and they listened." Another relative said, "They listen because they know I will tell them only once." However, a third person told us of having the phone put down on them three times when discussing matters with the office. There were systems for identifying complaints. The expectation for anyone's complaints to be passed onto the registered manager was written into staff job descriptions and interview processes.

However, we found complaints were not identified, recorded, handled and responded to effectively, despite prompt and apologetic replies. There were four complaints within the service's complaints file, dating from December 2016. The response letter to the most recent complaint was not appropriately responsive. It

asked the complainant to contact the registered manager about what the preferred visit time was, in relation to the visit being late according to the complainant. However, the requested visit time was included in the complaint. It referred to speaking with the staff member who visited the day after the date referred to within the complaint. It also explained that medicines were not missed because staff were sometimes not due to visit. However, our checks of gaps in the medicine administration records (MAR) for that period found there were occasions when staff visited but had not entered anything on the MAR.

A letter showed the complainant cancelled the service shortly afterwards, citing most aspects of the complaint as reasons. The provider's response to the complaint had not given the complainant options on what to do if they were dissatisfied with the complaint outcome. It was evident the service's response had not addressed the complaint to the complainant's satisfaction.

A complaint from January 2017 was about staff arriving at 15:30 for a 13:00 visit, resulting in the person's personal care and medicines needs not being met. The registered manager's documented response was that staff were having difficulty getting to the person's home. She told us that it was in the wrong geographical area, and public transport had let the person down. Whilst this could explain a degree of delay, it did not explain the staff member being two and a half hours late. The complaint record did not include a copy of visit plans for that day, any other records of investigation, or a copy of the provider's response to the complainant. This was not therefore an effective response to the complaint.

None of the four complaint records identified which member of staff was involved in the complaint. This was despite a prompt for that information within the incident reports that the service used to document the complaint. This demonstrated ineffective systems for recording and handling complaints.

We found an additional record of dissatisfaction within one person's care files. A social worker informed the service in June 2017 that a second staff member had not attended on one occasion when two staff were required to visit together. The response from the service confirmed that a staff member had been running late based on reviewing records; however, there was no copy of records kept in support of that. This matter had not been identified as a complaint as it was not in the complaint file, nor was it included in the numbers of complaints the provider declared to us within pre-inspection paperwork. This demonstrated ineffective systems for identifying a complaint.

The provider's complaints policy did not stipulate what records will be kept in respect of any complaints made. It was not therefore sufficiently robust at ensuring an effective system of recording complaints.

The evidence above demonstrates a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people and their relatives told us of the service assessing their needs before or as the care started. Comments included, "She went through all what was wrong from the patient's point of view, all the health hazards, going through a lot of questionnaires" and "They did come and assess my mum's needs." Care plans were put in place for people shortly after starting to use the service. They were specific to the individual's needs. For example, one new person's plan highlighted that staff were to be patient and avoid rushing them. Another's included exactly where their night clothes were to be placed after use.

Records showed that there were monthly reviews of people's services. One person's file had a record of a face-to-face review meeting after six months of service provision. It involved the person, a relative, the registered manager and a staff member. This helped to ensure wider care issues such as for upholding infection control were being planned for, and agreeing who would do what. It also showed satisfaction with

the standard of service being provided.

Inadequate

Is the service well-led?

Our findings

At our last inspection, we found some records about people using the service and the management of the service were not accurate or complete. This meant the provider was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection there was some improvement in the accuracy and completeness of records. For example, monthly reviews of people's care were now being documented. Staff supervisions were now recorded on a template that prompted for various questions and for which substantive answers were provided. All records we requested were now made available to us.

However, the provider remained in breach of regulation 17 primarily due to failing to identify the concerns we found during this inspection. For example, our findings in respect of complaints management showed issued raised by people about the service they received were not investigated robustly. This showed us the provider's quality and risk auditing processes were ineffective. This matched some feedback we received from involved health and social care professionals.

Records of care delivery and medicines charts were brought back from people's homes on a regular basis and held securely in the office. However, these records had not been reviewed in detail, to identify care delivery risks. Our checks of these records showed cases where medicines charts had not been signed despite staff visits occurring, and occasions when expected care visits were not recorded as occurring.

The provider had a Late and Missed Visits policy. It required for people using the service to be kept informed, and for a record of the matter to be reported to the management team so that planning to prevent repeat scenarios could occur. However, there were no such records. As our findings indicated late and missed visits had occurred, the policy was not being followed. Therefore governance of late and missed visits was ineffective at reducing the risk of reoccurrence.

There continued to be cases where records were inaccurate or incomplete. A bowel chart for one person stated they had blood in their stool for over six months. The registered manager confirmed this was inaccurate documentation. A spot-check by senior staff on a staff member at one person's home was recorded as taking place at 14:30. However, the care delivery records for that day stated the staff member left the person's home at 12:30 and returned at 16:15, meaning one of the records was inaccurate. The provider's response to a recent complaint included reasons why an incident occurred and actions taken by the staff member at the time to promote safety. However, care delivery records at the time of the incident made no mention of the incident and the actions taken, and so were inaccurate.

During the office visit, we were given on request a visit list for everyone using the service between 17 and 30 July 2017. When we subsequently asked the registered manager why there were gaps in the visit schedule for one person, the registered manager informed us none of the visits had occurred as the person had cancelled all visits. Whilst that may have occurred in practice, the document supplied was a plan, and so was incomplete in respect of visits that were planned to occur.

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

We found the provider was not consistently open and honest with us. At our request before the inspection, the provider sent us a list of the people using the service at that time and staff involved in undertaking care visits. Eleven people and six staff were declared. During the course of the inspection, we found that these lists were incomplete as we identified seven additional staff providing care, four during the course of our visit, and three other staff named by people who spoke with us.

There was a record in May 2017 of a senior staff member checking the care delivery at someone who was not declared in the list. During a staff member's supervision in July 2017 and when we spoke with the staff member after the inspection visit, they mentioned ongoing care of this person, so the person should have been declared to us.

Two of the people whose files we checked had care visits in advance of a previous list of people using the service that was sent to us on request in February 2017. Their names were not on that list, nor was the name of the person involved in the one safeguarding case involving the agency, despite the safeguarding incident occurring just six days after that list was sent.

This failure to provide all requested information undermined the inspection process and demonstrated a lack of transparency about how the service was being managed. This is not a breach of regulations but influences the well-led rating.

Despite the above concerns, we found the provider had developed their quality auditing processes in some ways. The registered manager told us of phone calls made to people and their relatives on a fortnightly basis, to check how the service was. Most people and their relatives confirmed this occurred, for example, "Every so often I get phone call from there to see whether everything is going okay."

The registered manager told us of hiring consultants to audit and support the service. One was to help improve on the findings of a recent monitoring report by a local authority. Actions had been taken as a result of their findings, for example, implementing a staff rostering system, improved staff training, regular staff meetings, and more comprehensive risk assessments for providing care to people.

Records showed that staff meetings occurred on a monthly basis. They were used to remind staff about appropriate procedures such as for promoting people's safety and wellbeing. Staff raised working practice matters which the registered manager helped to clarify. Memos also reminded staff on appropriate practices and to keep the management team informed if there were any concerns with people's safety or wellbeing. Staff told us the management team were approachable and "quick to give us what we need."

The registered manager had been registered since the service began operating over five years ago. They had relevant nursing and management qualifications. They were also the sole director of the company registered to provide this service.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered persons failed to ensure that care of service users is appropriate, meets their needs, and reflects their preferences. Regulation 9(1)(a)(b)(c)

The enforcement action we took:

We served Warning Notices on the Registered Provider and Registered Manager to become compliant with the regulation by 30 September 2017.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered persons failed to operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. Regulation 16(2)

The enforcement action we took:

We served Warning Notices on the Registered Provider and Registered Manager to become compliant with the regulation by 30 September 2017.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not effectively operated to ensure compliance with the regulations. This included failures to: • assess, monitor and improve the quality and safety of the services provided; • assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others; • maintain securely an accurate, complete and

	contemporaneous record in respect of each service user; • maintain securely such other records as are necessary to be kept in relation to the management of the regulated activity. Regulation 17(1)(2)(a)(b)(c)(d)(ii)

The enforcement action we took:

We served Warning Notices on the Registered Provider and Registered Manager to become compliant with the regulation by 28 October 2017.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered persons failed to ensure persons employed for the purposes of carrying on the regulated activity were of good character, and failed to ensure the following were available before employing anyone to provide care: •□A criminal record certificate •□Satisfactory evidence of conduct in previous care employment •□A full employment history, together with a satisfactory written explanation of any gaps in employment. Regulation 19(1)(a)(3)(a) S3 parts 3, 4, 7.

The enforcement action we took:

We served Warning Notices on the Registered Provider and Registered Manager to become compliant with the regulation by 30 September 2017.