Spring Care PAs Battle Limited

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Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

About the service
Spring Care is a domiciliary care agency that provided support and personal care to older and some younger adults with a range of needs for example, those living with dementia, epilepsy and diabetes. At the time of the inspection, the service supported 52 people, 46 of whom received personal care.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating and drinking. Where they do, we also consider any wider care provided.

People's experience of using this service and what we found
People told us they felt safe. Staff were split into three geographic teams which meant that in most cases people had the same small team of staff supporting them. There were no reports of missed calls and a system was in place to manage when a staff member was delayed when making a care visit. Staff understood safeguarding and were able to tell us what steps they would take on identifying risks to people. Assessments were carried out to identify risks and these were regularly reviewed. Staff were recruited safely and were employed in sufficient numbers to meet all care calls and needs. Accidents and incidents had been reported, recorded and investigated with any learning being shared with all staff and steps put in place to prevent recurrence. Some people required support with their medicines and this support was provided safely by staff trained in medicine provision. Infection prevention and control measures were in place and were regularly reviewed in line with government guidelines.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. Some people lived with variable mental capacity and best interest meetings had taken place. Mental capacity assessments were carried out when required. Pre-assessments of people's identified needs for example, epilepsy and diabetes were recorded and managers were able to ensure that staff had the required training and skills to look after people. Staff received a comprehensive induction which was supported with ongoing regular supervision meetings and a full training program. Some people received support with eating and drinking. People were supported to make choices about their health and social care needs.

Staff had received training in dementia and how to support people with communication needs. Staff told us about the importance of listening to people, looking at body language and signs that they were not feeling well. A complaints policy was in place and people and relatives were confident in raising issues and concerns. Care plans provided details of discussions concerning end of life care. This was person-centred and considered all aspects of people's needs and wishes including their faith and culture.

Everyone we spoke to, spoke well of the registered manager. People, relatives and staff all had ways of providing feedback about the service. For people, this was achieved through a regular questionnaire

although people told us that they could raise any issues with the registered manager or staff at any time. Care plans were person-centred and were accessible to all staff via a mobile telephone application. This had enabled staff to quickly update themselves on recent events and care visits and managers could quickly oversee care plans, picking up any trends or alerts. The registered manager used the application to conduct audits and reviews. The registered manager was aware of their responsibilities under the duty of candour which involves telling us and the local authority about important events that affect individuals and the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Requires Improvement (published 22 October 2019) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made and the provider was no longer in breach of regulations.

Why we inspected
We carried out an announced, focused inspection of this service on 26 April 2021. We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Effective, Responsive and Well-led which contain those requirements.
The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from requires improvement to good. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Spring Care PAs Battle Limited on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-Led findings below.

Spring Care PAs Battle Ltd

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
An inspection manager and an inspector attended the office. An Expert by Experience made telephone calls to people and their relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the inspection visit because we needed to be sure the registered manager would be available to support the inspection. What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. Due to the COVID-19 pandemic and in order to minimise our time spent in the office, we requested that several documents were sent to us by e-mail. For example, policies and procedures, business and contingency plans and the staff training matrix. We spoke to four members of staff. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We visited the office on 26 April 2021 and spoke with the provider, registered manager and one team leader. We spoke with four people and four relatives. We viewed a range of records including four care plans, medicine records, safeguarding and accident and incident records. We looked at three staff files to look at recruitment processes and a variety of records about the governance of the service including files relating to auditing, complaints and compliments.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and complaints policies. We spoke to two members of staff and three professionals.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now improved to good.

This meant people were safe and protected from avoidable harm.
Staffing and recruitment
● At the last inspection, we found issues in relation to insufficient time being given to staff to travel between calls which had resulted in some late and some missed calls. We saw that improvements had been made.
● Staff were arranged into three geographic teams and rotas compiled for each area. Enough time was given to carers to complete their care calls and travel between calls. The mobile telephone application enabled supervisors to see if a carer was either running late or had required more time at their last call. No missed calls had been reported. Contingencies were in place to cover late calls and people were always alerted by a telephone call. A feedback questionnaire showed that 31% of people rated the service timekeeping as outstanding and 62% said good.
● Staff had been recruited safely. New members of staff had been recruited during the Coronavirus pandemic and an online application was used followed by a video interview. Prior to starting work, checks were carried out including references, checks on any gaps in employment, photographic proof of identification and Disclosure and Barring Service (DBS) checks. DBS checks provide information about people's previous convictions or cautions and ensures that potential staff are safe to work within the care sector. We looked at personnel files and saw all this information documented.
● The registered manager ensured that there were always enough trained staff to meet people's needs. Only staff who had completed appropriate training were able to look after people who lived with health concerns for example, epilepsy, diabetes and those using PEG feeds.
● Staff were matched with people according to their skills and with people with whom they were likely to have a rapport and get on with. As far as is practical people had the same small group of carers that visited them each time.
● Comments from people we spoke to included, "They are absolutely marvellous, they stay for long enough," "They do stay for as long as I need them," "They let me know if they are going to be late," and "I usually have one of three and it's mostly the same person unless they are on holiday." A relative told us, "They have never missed a call. They are on time but will always let us know if they are going to be late." Staff rotas were on a template that was shared with people.

Systems and processes to safeguard people from the risk of abuse
● People were safe and protected from the risk of abuse because staff understood people's needs and knew how to respond to risks. All staff had received safeguarding training and were able to tell us the action they would take if they had concerns. A staff member told us, "I'd ask about sharing the information. I'd ask for permission to take photos if needed then report everything to my managers." Another said, "I'd report straight away. I have had to do this and the manager responded immediately."
● People told us they felt safe. A person told us, "I have a key safe and they always lock the door when they

go." Another said, "I do feel safe and have no worries." A relative said, "My relative is definitely safe."
● The registered manager told us about 'making safeguarding personal.' This is an important part of investigating safeguarding, which ensures the person's wishes are at the centre of any enquiry. They told us of an incident that they reported to CQC and the local authority where another family member was involved. The registered manager explained that additional care calls were put in place and by working with the local authority they ensured the person was safe.
● Staff were aware of a whistleblowing policy and felt confident to use this process if needed. Whistleblowing protects the anonymity of staff when raising concerns.

Assessing risk, safety monitoring and management
● Staff knew people well and were aware of potential risks. The service recorded care plans and daily notes on a mobile telephone application which all staff accessed and updated. A member of staff told us, "I'll read the latest notes on a care plan before going in. It's great, I'm fully up to speed before I go in."
● The application provided detail of known risks to people for example, those living with epilepsy or diabetes and gave detail of emerging risks. For example, a carer recorded a person appearing confused and disorientated. The person's GP was contacted, and the care calls were extended in time. All this information was immediately available to the carers attending future calls.
● Care plans included risk assessments relevant to people's care and support needs. We looked at care plans which assessed for example, dietary requirements, moving and handling needs and skin integrity. We saw detailed assessments for managing those people who lived with epilepsy. These risk assessments contained detail of exactly what staff should do in the event of a seizure and what signs to look out for if a seizure was likely.
● Another specific risk assessment was in place for the use of a Percutaneous Endoscopic Gastronomy (PEG) tube. This is a tube that enables food, fluid and medicines to be passed directly to a person's stomach when they are unable to swallow safely. The assessment detailed safe use and maintenance of the PEG tube and the action required in the event of it not working correctly.
● Environmental risks were documented as part of people's initial assessment and continued to be monitored at each visit. This included safe access to people's homes, any risks relating to electrical or domestic appliances and any trip or other hazards within the home.

Using medicines safely
● People who needed medicines were supported by staff who had been medicines trained and were competent to administer. A staff member told us, "A lot of people self-administer, and others have pre-prepared blister packs, but we always check to make sure." Another staff member said, "We have refresher training and on-site checks by supervisors."
● People told us that they were supported by staff with their medicines, one person said, "My tablets are kept in the kitchen, they sort them out for me." Another said, "They sort out my medication, but I do my own afternoon tablet."
● Care plans had medicine administration records (MAR) attached. Medicine administered was recorded electronically and it was clear to see the date, time and quantity of medicine given and the name of the staff member involved. This system was monitored remotely by managers and any late, missed or declined medicines were immediately identified and checked. GP's were consulted in the event of medicines being declined.
● Some people received as and when required medicines (PRN). These included for example, pain relief medicines. Care plans provided details of when people may require PRN medicines and action staff should take. A separate protocol was in place for PRN medicines. Staff were aware of the protocol and the individual needs of people they cared for. A staff member said, "I'd always check with the office if unsure or the on-call supervisor. Anything unusual and I'd call the GP."

Preventing and controlling infection
We were assured the provider had provided infection prevention and control boxes to people's homes.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Learning lessons when things go wrong
● Accidents and incidents were reported, recorded and investigated with any learning and best practice shared with staff. The electronic care plans had a 'contact the office' alert which staff used in the event of an incident to alert managers and to seek advice and support if needed. Managers responded to the alerts, made assessments, and serious incidents were escalated to the local authority and CQC.
● One care plan showed a person having experienced three falls within a week. Correct alerts were sent by staff, managers identified the trend and immediately acted and called the local authority falls team to provide additional support.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now improved to good.

This meant people's outcomes were consistently good, and people's feedback confirmed this.

Ensuring consent to care and treatment in line with law and guidance
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. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

At the last inspection the provider had failed to ensure that power of attorney documents were kept by the service. Relatives had signed consent forms without authorisation from people. There was no evidence of best interest meetings taking place. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 11.
We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
- Where appropriate, people had power of attorney documents in place. These are legal documents that allow other people to make decisions on people's behalf relating to health, welfare and finance. The registered manager had spoken to people about these arrangements and some people and their advocates had consented to copies being held by the service. Some people preferred these documents to be kept private and this was respected by the registered manager.
- We looked at several care plans and saw that people had signed to consent to personal care and for other aspects where the service looked after them for example, having their photograph taken to attach to care plans. In some cases where people lacked or had variable capacity, these signatures had either been countersigned by a relative or in some case signed on their behalf.
- Where people lacked mental capacity, some decisions had been made on their behalf. These decisions

had been made at best interest meetings involving people, relatives, staff and professionals and were documented as part of care plans. Care plans gave details of 'decision makers' and that this had been agreed with the person. The service was not currently looking after anyone with a Court of Protection ruling.
● Staff were aware of the importance of consent. A staff member said, "I always ask before I do anything. If unsure and there are family there, I'll ask them too." Another told us, "I ask every time. I looked after a lady recently who was very sleepy during personal care. Each time she woke I asked again and reassured her that it was her choice." A person told us, "They ask me each day if I want a bath and if I say no, they'll put it off till a different day. They always ask me."
● Staff demonstrated an understanding of mental capacity and all staff had been trained. Mental capacity assessments were included in care plans and these showed decision specific questions that had been addressed for example, consent to personal care. Care plans also gave detail of non-verbal signs that a person might use if uncomfortable for example, hand gestures if wanting personal care to stop.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The registered manager carried out assessments of people to understand their care and support needs, their likes, dislikes and any preferences to the way they want to be looked after. Some people were living with specific needs for example, epilepsy, diabetes or dementia. The assessment explored these needs and ensured that enough staff with the necessary skills and training were available to support them.
● During the pandemic initial assessments had been conducted over the telephone or using video conferencing. An environmental assessment of the person's home was always carried out during the first home visit.
● People and relatives were involved in care planning and reviews. A person said, "We did the care plan the other day and (relative) was involved." A relative told us, "There is a care plan. It was done right at the beginning. We are involved in the care plan and discuss it with the carer."
● People had access to health and social care professionals. During the pandemic district nurse and occupational therapists continued to visit people and the registered manager told us that if a person needed medical support, they had arranged video calls with local GP surgeries. If the help required involved something that was visible then, with consent, photographs were taken and sent to the GP for assessment. The registered manager said that this was a very efficient process resulting in quicker assessments than waiting for a GP to visit.
● A relative told us that their relative's health had declined and that it became necessary to call in a district nurse and then later consult the GP. The relative told us, "We had a discussion with the carers and the nurse and together we found a way forward. The staff took on board all the recommendations made, absolutely." They went on to say, "They are micromanaging care and offer them help where appropriate. The medication was changed by the GP."

Staff support: induction, training, skills and experience
● New staff had a comprehensive induction. Throughout the pandemic some of the initial training and familiarisation had been completed using video links or online training programs. All new staff shadowed more experienced staff for several shifts and were given ongoing support from supervisors.
● A staff member said, "We are given the tools to do the job. I see supervisors nearly every day and I can call the office at any time if I need help." Another told us, "The training covers all of my work needs." A supervisor told us, "New staff on my team shadow me with all clients. I observe as they start to take over and then I'll carry out regular spot checks." Spot checks are unannounced supervisory checks when staff are in people's homes.
● Formal supervision meetings took place in accordance with the providers policy and records of these

meetings were held on staff files.
● The service had a training manager responsible for overseeing the induction process and ensuring that all staff completed training and refreshers in a timely way. We saw an updated training matrix that confirmed that staff were up to date with all aspects of training which included, moving and handling, safeguarding and dementia training. A relative said, "They know exactly what they are doing. Their training is ongoing."
● People living with particular needs for example, those living with a PEG tube, diabetes or dementia, only received support from staff who had training in those areas. A staff member said, "The training covers all of my work needs. The manager told me that any training I want to do that would be useful, just ask."

Supporting people to eat and drink enough to maintain a balanced diet
● People's nutrition and hydration needs were met. Some people prepared meals themselves and others had support from relatives. In some cases, staff helped people.
● Nutritional needs were considered at people's pre-assessment before they started to receive support. Details were in care plans and if any changes occurred the managers were alerted and referrals to specialist teams made if required.
● Some people had dietary needs for example those living with diabetes and those with a PEG feed. Staff had the necessary training to manage these needs safely.
● People told us that staff supported them with meals and drinks. Comments included, "They do my meals and tell me what I've got so I can choose. They do my shopping," "I have asked them to peel some potatoes for me which they did" and "They do all the food at the moment."

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now improved to good.

This meant people's needs were met through good organisation and delivery.
End of life care and support
● At the last inspection we found that there had been no discussions with people or their relatives about end of life plans and no record of people's wishes were recorded. It was not always clear where Respect (Recommended Summary Plan for Emergency Care and Treatment) forms were kept. We saw that improvements had been made.
● People's wishes and choices were discussed at the initial assessment and reviewed throughout. The registered manager told us that not everyone wanted to discuss this issue and that was respected and recorded in the care plan. A relative told us, "My relative has an end of life plan and a just in case (JIC) box. I would recommend them (the service), I'm very impressed with them." JIC boxes are provided by GP's and contain pain relief and other medication to be used if needed.
● Respect forms had been completed which supported conversations about care in a future emergency.
● The service was experienced in providing end of life care to people. Staff knew the important aspects of care at this stage of people's lives. A member of staff said, "We make sure people are comfortable, clean and safe. Very aware of the need to turn people to avoid pressure sores developing." Another said, "Respecting people's wishes. (service user) wanted to stay at home and be with family. We received excellent feedback from the family."
● A relative told us, "My relative is now receiving end of life care, it's discussed and it's all documented."
● Staff had received recent training in end of life care. Training records showed nearly all staff had received training with refresher courses scheduled.
● Care plans had a section about end of life / palliative care. Risks were highlighted for example, the higher risks of developing pressure sores and the need to safely re-position people regularly. Personal details were also included about people's final wishes. A member of staff told us that the end of life plan for one person was, "Lovely to read and enabled me to pick up exactly what the person wanted."

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
● People told us they had choice and their preferences, likes and dislikes were respected. One person told us, "They know me well. They are extremely co-operative. If I ask them to hang the laundry out, they'll do it because they know I can't." A relative said, "My relative has the same person in the mornings which gives continuity of care. They are not rushed and have time to sit and chat."
● Pre-assessment conversations, about their preferences, ran through people's care and support needs including for example, moving and handling wishes. Care plans showed in detail how people liked to be moved whether using slings or hoists and preferences when going out, whether to use a wheelchair or frame and exactly the level of support they required to ensure safety whilst maintaining preferences. For example,

some people preferred to try and walk, and their wishes were always respected. A professional said, "They are definitely straight on to us after their pre-assessment if they need any support from us."
● At the pre-assessment there were always discussions about skin integrity and people's susceptibility to pressure sores. A risk score was created for each person which helped staff to know what to look for and what action to take if needed.
● Staff knew people well. Care calls were managed to ensure the same small pool of staff visited the same people which helped them build a rapport with people and to be able to identify quickly any changes that may indicate they were unwell.
● People and their relatives were involved in care planning and reviews. A person said, "We did the care plan the other day and I was involved." A relative told us, "There is a care plan, it was done right at the beginning. We were involved in the plan and discussed it with our carer. A nurse was involved as well."

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Staff knew people well. Staff were split into geographic teams which meant they cared for the same, small group of people, all the time. This enabled staff to get to know people, their needs and any communication preferences well. A member of staff told us, "I talk with people all of the time, but you get to know their nonverbal signs and body language. I know without asking if (name of person) wants me to stop doing anything."
● The registered manager told us about support they provide to visually impaired people. They approached the Blind Society who made an accessible copy of their Service User guide. The training manager attended a course ran by Guide Dogs for the Blind. The training manager then ran a training session for all staff.
● The service worked closely with family members to understand the best way to communicate with people. This was explored during the pre-assessment with preferences recorded including whether people required large print formats in written documents and whether they preferred to receive texts or e-mails. One person gave hand signs and signals to indicate whether they were happy, were agreeing to personal care or were feeling unwell.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● People's social, religious and cultural needs were discussed, supported and promoted. People and their relatives were asked about their faith for example and if they had any particular needs. We saw these aspects of people's care and wellbeing were discussed at reviews and relatives and loved ones were involved in explaining what was important to people.

Improving care quality in response to complaints or concerns
● The service had an up to date complaints policy. The policy was accessible online, as part of infection prevention and control during the Covid-19 pandemic not everyone had a copy in their homes to minimise the amount of paperwork in people's homes. Everyone we spoke with felt confident in raising issues and knew how to.
● Comments from people included, "I have no complaints," "I have not needed to make a complaint," and "It's easy to get hold of the office if I need to." A relative told us, "The manager is easy to get hold of. She listens and is active in responding."
● The system for complaining was easy to follow. To highlight to people how to complain if needed, team leaders when first meeting new people, ran through the process with them face to face. One person said,

"The only complaint I have made was when they sent a male carer. They sorted that out quickly."

● No recent complaints had been made but three, received since the last inspection, were seen in records held by the registered manager. These had been clearly and concisely recorded with a summary sheet allowing a quick overview for managers to review and identify themes. Resolutions were shown including a copy of letters sent to people with an apology and details of how to contact CQC if not satisfied.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now improved to good.

This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

At the last inspection two incidents involving the police or where alleged abuse had occurred had not been reported to CQC, the registered manager did not fully understand their responsibility to notify us of these incidents. This was a breach of Regulation 18 Notification of Other Incidents of the Care Quality Commission (Registration) Regulations 2009.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

- The registered manager was aware of their responsibility under the duty of candour. Registered managers are required by law to notify the CQC of any incident of abuse, incidents where the police are involved and other incidents where a person may be at risk of harm. The registered manager had complied with this and several notifications had been received by us which we saw had been recorded by the service. Throughout the inspection the provider and registered manager were open and honest with us about all aspects of their service.
- The registered manager maintained clear oversight of the service through a process of regular auditing. This process has been made easier with the introduction of the mobile phone application which gave managers immediate access to up to date information. Through the application, audits of care plans, medicine records and daily notes were carried out.
- Staff understood the importance of reporting accidents, incidents and safeguarding matters and these were all recorded and reviewed by the registered manager. Prompt action was taken in each case with any learning being shared with staff.

service.

- The service has a website. A link to the latest CQC report was found attached to the website.

At the last inspection the registered manager had not ensured good governance had been maintained. Records were not up to date and consistently accurate. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17.

● We looked at six care plans during the inspection. Care records were up to date and accurate, reflecting people's current needs and wishes. Recent trends were easy to identify for example, if a person had declined personal care, a shower or bath or food and drink, this was immediately seen by the next carer and was overseen remotely by the registered manager. Any ongoing concerns then were addressed.
● Care plans had been improved and now contained personal details including people's preferred name, details of faith and cultural needs and any issues relating to communication for example.
● Some people lived with specialist needs for example a PEG feed, epilepsy, diabetes and restricted mobility. Specific care plans were now in place providing detail about how to manage these needs. For example, staff were trained in all aspects of moving and handling, the use of slings and hoists and were aware of risks associated with people who spend all their time restricted to bed. People were encouraged to be as independent as possible throughout moving and handling procedures.
● People living with epilepsy had bespoke risk assessments indicating signs and triggers for people who may be about to experience a seizure. People living with diabetes similarly had care plans with fluid and food charts so staff could monitor intake and sugar levels. Contingencies were clearly laid out for staff in the event of a seizure or a diabetes incident. This level of detail in care records was missing at the last inspection and at this inspection the provider had made improvements.
● We found that the new mobile telephone application had greatly improved management oversight of accident, incidents, care calls that ran late and any issues with provision of medicines. Details of all these issues were immediately picked up remotely by managers and were dealt with efficiently. Staff were able to send an instant message to managers using a 'contact the office' notification on the application. An example of this is where a member of staff needed a district nurse to attend and this was arranged immediately following the request.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The registered manager was thought of highly by people and relatives. A person told us, "I think they are good managers; they do their utmost to accommodate me." A relative said, "They are a good manager, very approachable, very empathetic. She listens to me and is active in responding." Another relative said, "I do ring the office sometimes, it's easy to get through to them. I would recommend them to others."
● Professionals told us of a positive working relationship with the registered manager. One told us, "I have a lot of contact with (registered manager), always approachable. Team leaders are also in place which is helpful." Another professional said, "I've worked with the service for several years, the manager always responds and is forthcoming in contacting us."
● Similarly, staff reported a positive culture promoted by the registered manager. Comments included: "Very supportive, calm and approachable. I never feel ignored," "I've had great support following a bad experience at my last place at work," and "I've worked in care for 26 years. Spring Care are up there. The personal care is outstanding and the manager is great."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The registered manager understood the importance of listening to people and obtaining feedback about the care provided. Annual questionnaires were sent to people seeking feedback and a full review of every person was carried out four to six weeks and then every six months, after they started using the service.
● The registered manager reported that during the pandemic a lot of informal feedback was being captured and reported by staff. From the latest review we saw the following comments: "Care is wonderful, I couldn't

wish for better people around." A relative said, "We've completed a couple of questionnaires."

● Staff surveys were completed every six months and recent returns were very positive with 97% of staff reporting to feeling positive about the company and 100% believing they were making a difference to people's lives. A question was raised by staff relating to them having to complete a lot of online training in their own time. This was picked up by the registered manager who introduced financial rewards for staff who had completed their training.

● Staff meetings were held every four to six weeks. During the pandemic the frequency of the meetings remained the same, but the format moved to using conference calls and WhatsApp messaging. Staff told us that they had many opportunities to provide feedback. A staff member said, "As well as the meetings we are on the phone all the time. They are always there to support. The support continued and I was never ignored even during a period when I was absent from work."

● We saw a compliments folder that had several recent messages from people, relatives and professionals. A person had written to say that staff, "Go above and beyond." A professional had sent an e-mail to that staff were, "Kind and helpful."

● People's equality characteristics were considered and promoted. For example, people's faith, cultural needs and dietary requirements were all explored during the pre-assessment process and kept under review. All this information was accessible to staff from the care plans.

Continuous learning and improving care

● Since the last inspection improvements had been made in care plans. Care plans were now person centred and included detail about people's specific care and support needs. Systems were in place to report accidents, incidents and safeguarding with clear management oversight and any learning shared with staff.

● The registered manager told us that some of the new ways of working during the pandemic improved the efficiency of the service and the care provided to people. For example, enabling some staff to work from home and to join meetings remotely cut down on travelling time, creating more time for staff to travel between care calls without missing out on the meetings themselves.

● The registered manager attended a three-monthly managers forum and had kept in touch throughout the pandemic with bulletins from the local authority, CQC and Public Health England (PHE). Key messages from these updates were shared with staff.

Working in partnership with others

● The registered manager had fostered positive relationships with district nurses and occupational therapists, and this had continued during the pandemic. A professional told us, "We've worked well together in quite complex cases. They also raise concerns with me and work well as part of a multi-disciplinary team, especially with reviews of people."