

Ison Nursing Agency and Care Services Limited

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Inspection report

128 High Street
Edgware
Middlesex
HA8 7EL

Tel: 07985418900
Website: www.isonna.co.uk

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Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Inadequate 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This was an announced inspection that took place on 4, 10 and 11 May 2016. At our last inspection in January 2016, we found nine breaches of regulations. These included about risk management, person-centred care, consent, dignity, complaints, recruitment, staff support and good governance. We undertook this comprehensive inspection to check on the progress made by the provider, and because of concerning information that had been reported to us about the service.

The agency is registered to provide homecare services to anybody in the community. There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was also the nominated individual for the registered provider.

At the time of this inspection the agency was providing a care service to 38 people in their own homes. Whilst the agency is registered to provide nursing care to people in their own homes, the registered manager told us this was only occurring for one person.

The provider's action plan in response to our last inspection told us they would have addressed all the regulatory breaches by the time of this inspection. However, at the start of this inspection, the registered manager gave us an updated action plan that clarified that they had not addressed some breaches as quickly as anticipated and so there was ongoing work to complete matters.

We found that the provider was making improvements to the service, and was thereby improving on service quality that people received. However, they remained in breach in the following four areas:

People did not always receive safe care and treatment. This was because people were not safely supported with taking medicines, and records of this support were not properly kept. Additionally, actions were not taken to reduce foreseeable risks in relation to people's specific needs, including for nutrition and pressure care.

Staff support did not always enable effective care delivery. This was because new staff did not receive adequate induction before providing care, staff were not routinely supervised, training was not effectively provided for nutrition and pressure care awareness, and staff did not always receive realistic visit schedules.

Complaints were not always handled and investigated effectively. Some complaints were not responded to, and investigation processes did not always address matters effectively.

Governance systems were not yet effective at reducing risks to care delivery. Governance systems were being developed that helped identify service risks to people's welfare, but actions to address identified risks

were not yet effective, including for ensuring that people received the full length of their care visits and that staff were not late. Records about people's care and the management of the service were not consistently accurate and complete, despite improvements to care delivery records and their oversight.

Further surveys had been sent to people since our last inspection for their views on service quality. There was ongoing work to analyse these, to identify what worked well and what needed improving. Staff had also now been sent similar surveys.

Care assessment and planning did now incorporate the views of people using the service and their representatives where appropriate. New care plans were better at guiding staff on addressing people's needs and preferences, although the registered manager acknowledged that this reviewing and updating process needed completing for some people.

The provider had updated systems to acquire consent to care delivery. These had been used properly so as to gain valid consent or establish that best interests processes were needed.

The service continued to provide a consistent set of care staff to most people, which helped to build positive caring relationships. Most feedback we received indicated that the service supplied caring staff.

Staff were now supplied to provide care to people only after appropriate checks of their character were completed.

Spot-checks of staff in people's homes were now being regularly undertaken. They were being used to check on a range of service quality markers including people's views of the service.

There were overall four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last comprehensive inspection this provider was placed into special measures by CQC. This inspection found that there was not enough improvement to take the provider out of special measures.

We are taking enforcement action against the registered provider and the registered manager. We will report further on this when it is completed.

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. People were not safely supported with taking medicines, and records of this support were not properly kept.

The service checked risks to service delivery in people's homes, but action to reduce risks was not consistently taken.

Recruitment procedures made sufficient checks of prospective new staff members' character and identity.

The service had procedures for safeguarding people from abuse.

Is the service effective?

Requires Improvement ●

The service was not consistently effective. The support and training of staff, especially new staff, was not always effective at ensuring staff had the skills needed to provide effective care to people.

People received adequate support for nutritional and health needs, although staff training did not always support this.

The service was following basic responsibilities about the Mental Capacity Act 2005 and people's consent to care.

Is the service caring?

Good ●

The service was caring. People's opinions, preferences and choices were sought and acted upon, and their privacy and dignity were respected and promoted by staff.

People received a consistent set of staff, which helped positive and caring relationships to develop.

Is the service responsive?

Inadequate ●

The service was not consistently responsive. A number of people experienced late visits, and staff were not always provided with visit schedules that realistically enabled them to attend to people on time.

There was ongoing work to review the service provided to people, to ensure that they received care that addressed their needs reflected their preferences.

The service did not consistently ensure that people's concerns and complaints were properly investigated so as to minimise the risk of reoccurrence where appropriate.

Is the service well-led?

The service was not consistently well-led. Governance systems were being developed that helped identify service risks to people's welfare, but actions to address identified risks were not yet effective. Records about people's care and the management of the service were not consistently accurate.

Requires Improvement 

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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 4, 10 and 11 May 2016. 48 hours' notice of the inspection was given because the service is a domiciliary care agency and the registered manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

Before the inspection, we checked notifications made to us by the provider, 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 two inspectors, a pharmacist inspector, an inspection manager and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. Their role was to phone a number of people using the service and family members about their experience of the service.

There were 38 people receiving a service in their home, and 42 staff at the time of our inspection. During the inspection process, we spoke with four people using the service, eight people's relatives, six care staff, two office staff, and the registered manager. We visited two people using the service, with their permission, as part of our inspection checks, along with contacting three local authorities for their feedback about the service.

During our visit to the office premises we looked at copies of seven care plans for people who use the service along with other records about people's care and treatment including visit schedules, medicines records and care delivery records. We also looked at the personnel files of eight staff members and records about

the management of the service such as staff visit schedules, complaint records and the provider's policies.

Is the service safe?

Our findings

Most people and their relatives told us they felt safe using the service. One person said, "They make me feel safe, make me feel less anxious." A relative told us, "I trust them 100%." When visiting one person, we saw staff carefully supporting them to get to a comfortable position.

Some improvements with medicines had been made. The medicines policy had been revised, care staff responsible for medicines now had their medicines competency assessed, and there was a new care plan with more information about medicines. Medicines risk assessments had been changed to include more information about medicines, staff had received training in how to complete the new medicines administration record (MAR) chart, and completed MAR were now returned to the office for checking once complete.

However, the arrangements in place for medicines were still not safe. When we looked at people's care plans and medicines records, there were inconsistencies and recording omissions on all of the medicines records amongst the five people we checked. None of the MAR were complete. People's prescribed medicines were not listed on their MAR, instructions for administration were not stated, and there were significant gaps in recording. We could not therefore tell what medicines had been given and if all prescribed medicines had been given. We could not be certain that people had received their prescribed medicines correctly.

One person's care plan identified that they were at risk of constipation because of their medical condition. Our checks of the MAR for a constipation relief medicine prescribed to be administered to them at night found only three confirmations of supporting the person to take the medicine across a recent 13-day period. When we checked care delivery records for nine of the remaining days, only two mentioned that the medicine had been given to the person. We noted that the person's care plan did not prompt staff to provide medicines support despite the risk assessment recording this prescribed medicine. This demonstrated a significant risk that the person was not provided with the medicine.

There was a recent record of the above person refusing to eat and being unwell, with staff stating that they appeared constipated. We noted that neither MAR or care delivery records just beforehand showed that the person had been supported to take prescribed anti-constipation medicines. These care delivery records demonstrated care that was not safe as they did not confirm that prescribed medicines was given to the person or that care staff reported any concerns with the person becoming constipated.

MAR were usually hand-written by care staff at people's homes. The list of medicines and instructions for use were not checked by another person before use, as required by the agency's medicines policy, to ensure that these were accurate.

The list of medicines in people's care records was not up to date and a record was not kept of when medicines were changed or stopped. In one instance, the registered manager told us that instructions had been taken from someone's relative to stop administering a medicine to this person, without the agency checking first with the prescriber.

There was inconsistent information in people's care records about the level of medicines support provided by the agency. The risks due to medicines or non-administration of medicines had not been properly documented, and some people had health conditions such as multiple sclerosis and Parkinson's disease where ensuring correct medicines administration was critical to their health.

The recent MAR audit for one person had picked up that there was still poor medicines recording. Care staff identified as not completing medicines records correctly had been sent a letter about this. From the records we saw for May 2016, MAR recording had not yet improved sufficiently.

The above evidence demonstrates that safe medicines support was still not being provided to people at the time of our inspection.

The registered manager told us of one person who had a pressure ulcer from the start of using the service. There was a turning chart in place, for which the person's plan stated for it to be filled in at each of the four daily visits. However, it had been completed only once in a 19-day period just before our visit. This included the five days after a care record audit identified the concern and advising that relevant staff had been coached on what was needed. This did not demonstrate that the person was provided with safe care and treatment in respect of pressure care needs, and that sufficient action was taken to address identified risks in that respect.

We noted other ways in which current risk assessments for people did not document adequate exploration of risk and actions to minimise risk. One person was using bed rails and was noted to be using a pressure-care mattress, but this was not part of their current risk assessment. Risks around infection control for another person, who received showering support and support to eat and drink, incorrectly stated that the person's family controlled any risks. Environmental risk assessments for most people did consider if there was enough space for any moving and handling support needed, but were too brief to show that all reasonable risks had been considered. Whilst we recognised that the provider was still reviewing and updating risk assessment processes in people's homes, current risks to people's care and treatment were not consistently being safely managed.

The evidence above demonstrates a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records demonstrated an improved staff recruitment procedure. This included an application and interview process, and checking of identity and right-to-work documents and work histories. Copies of relevant documents were kept along with a dated statement of seeing the original. Written references and a disclosure and barring (DBS) security check were promptly taken up. In most cases references were from previous care employers, and the registered manager undertook to acquire this in the one instance where this was not the case. There was a record of phoning each referee for additional checks alongside the written reference. Where anybody had information of concern on the DBS disclosure, there was a suitable written risk assessment about employing the person and what precautions were needed. We found that all these processes were now completed before staff started providing care to people. We were also shown an improved recruitment records process that guided office staff on making sure the correct checks were undertaken.

The registered manager told us there were enough staff employed to meet people's needs, and we found no instances of people failing to receive a planned care visit. The registered manager clarified that there were no nurses employed at the time of the inspection. One person was receiving care and treatment that involved some nursing practices. We saw that the staff member assigned to them had now been

professionally trained in those tasks and assessed by a nursing consultant as capable of supporting the specific person.

Staff received induction and refresher training on how to recognise abuse and possible harm to people using the service. They understood what abuse was and the action required if they should encounter it. Staff were also aware of how to raise a safeguarding alert and when this should happen. The service's safeguarding folder contained a copy of the updated PAN-London safeguarding protocol and good practice guidance. The folder included one entry for 2016 that showed action being taken to address concerns. This included meeting with relevant family members to discuss how to make improvements to the service.

Is the service effective?

Our findings

When we reviewed the comments we had from people using the service and relatives, the majority of viewpoints about the agency were positive, with comments such as "I would recommend the service to anyone" and "The service is really good." However, a minority of people disagreed, with a typical comment being, "The service is passable."

Most people and their relatives told us of staff being capable. People told us, for example, "I feel comfortable with them and they do the job reasonably. They seem to know what they are doing." Relatives said, "They are doing what they can. The current carers are trained nurses in their own country, they are very good." However, two relatives noted that when new staff started, they needed a lot of support. One relative said, "The new care worker had no idea what they were doing, so we had to talk them through it."

Most staff were happy with the training provided. They said they had had training recently and that these involved tests of understanding at the end of each course. One staff member told us that for hoisting people, "I had the chance to practice before sending me to hoist the people I care for and I also worked with experienced carers when I started to shadow their work."

The service provided staff with induction and on-going mandatory training. Training records showed that staff received training that included moving and handling, safeguarding, infection control, basic life support, food hygiene, and equality and diversity. Specialist training was also provided such as dementia awareness and end of life care. The registered manager showed us certificates of her recent trainer training for moving and handling, basic life support, medicines and end of life care, which helped ensure that she could capably provide these trainings to staff. We saw certificates in place for other senior staff for some such training. The registered manager told us further refresher training had been provided to most staff recently from an external training consultant. We saw staff certificates in respect of this. The registered manager told us that they were aiming to start providing staff with training in line with the new national Care Certificate or a nationally recognised qualification (QCF), depending on whether staff were new or established.

The registered manager told us that staff watched a video on meeting people's nutritional and hydration needs. However, our checks of staff files found no training records on this. There was no such training evident on the provider's overall staff training records sent to us on request after our visits. When we asked the registered manager for further evidence, she sent us a copy of the new training being provided to staff. However, whilst it explained many aspects of food hygiene training that was provided, it did not include anything on meeting people's nutritional and hydration needs. In light of our concerns identified for the unsafe nutritional support we identified for one person, this did not demonstrate that staff were provided with training that supported them to meet people's nutritional and hydration needs. There was also no reference to training on preventing pressure ulcers within the training documents supplied, despite some people having pressure care needs.

Staff induction training covered a broad range of topics relevant to the work staff were to perform. The registered manager told us it took place over three days, and that most new staff shadowed more

experienced staff before working alone. However, records of this were incomplete for two staff we checked on, and non-existent for two other staff members, all of whom started work in 2016.

In one case, the registered manager confirmed that the new staff member had not had a period of shadowing as they were judged as sufficiently experienced. However, this did not follow the provider's induction policy. We also found that the records the staff member made of one person's care, from when they first started providing care in people's homes, lacked detail. They did not include times of visits, or the names of the staff members, despite a recent care delivery records audits for that person identifying these matters for improvement. The registered manager subsequently confirmed that the staff member would now be shadowing senior staff until the staff member demonstrated improved record-keeping.

For staff working for over a year, we saw appraisal records that provided an opportunity to review progress and identify individual training needs. The registered manager told us that staff were ordinarily supervised every three months, which the updated supervisor policy confirmed. However, records within the five files we checked of staff who had been working since last year indicated that only one of them had received supervision in that time. The registered manager told us that staff supervision was work-in-progress. This was not sufficient support of staff to enable them to carry out their care duties.

The evidence above demonstrates a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's recent surveys of people's views showed that most people were happy with the nutritional support provided. One person told us, "They make sure I have something to eat." The registered manager was aware of hydration support needs for one person, and said that providing them with a straw to help them to drink had been beneficial. People's care plans included sections for health, nutrition and diet. Where appropriate, staff monitored what and how much people had to eat and drink.

Some care delivery records gave a clear indication that what meals staff supported people to eat, however, other people's records did not clarify or monitor what was eaten and drunk. The registered manager confirmed that that for one person, staff were not consistently documenting the support they provided with hydration. This did not assure us of people consistently received sufficient support to eat and drink enough.

Some records demonstrated that the agency liaised with relevant community health services. For example, where one person had a concerning cough, a GP visit was sought, and advice from them was taken on board to the extent that the registered manager visited the person the next day to reassess their needs.

We saw that the provider's new care records booklet included guidance to staff on different skin condition concerns, in support of helping staff to effectively manage any skin integrity concerns.

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 checked whether the service was working within the principles of the MCA. We found that people's consent to services was usually recorded in care plans. Where there was doubt that the person could consent to this, the registered manager had undertaken a capacity assessment

to help clarify whether or not this was the case. Where the person was found not to have capacity, a 'best interests' process was followed. We saw that this involved relevant family members.

The registered manager told us that she had recently attempted to reassess one person's needs, however, as the person was assessed as lacking capacity to make decisions about care from the service, and the main family member was not present, she had had to postpone completing the assessment. This was appropriate in the circumstances.

Attention was paid to whether people had Lasting Power of Attorney arrangements and how that affected decision-making processes.

We noted that privately-funded people had service contracts with the agency that stipulated specific costs.

Is the service caring?

Our findings

Most people and their relatives told us that staff were caring and respectful. One person said, "They are all kind and caring. I was a bit apprehensive before but they make it comfortable, we have a laugh and a little chat." Relatives' comments included, "They are very caring and considerate, they talk to her and watch TV with her" and "They are brilliant, gentle and kind. They chat with mum while she is in the shower. They have such a nice attitude, light-hearted, bright and witty."

We noted that recent survey replies, from people and their relatives directly to the agency, reflected the above feedback. A typical comment was, "My wife is treated with all care and respect anyone could wish for." When visiting one person, we saw staff interacting in a friendly manner and at a level that suited the person.

One person's care plan clearly stated that their wish for only female staff was to be respected. Staff visit schedules and care delivery records showed that the preference was being followed.

We saw that the new staff interview document included questions that put staff in the shoes of people using the service. This helped to demonstrate that empathic and understanding staff were being recruited.

The registered manager told us that if a person using the service can recall staff names, that helped to assure her that there was rapport developing and continuity of staff. Staff we spoke with had a good knowledge of the people they supported. They were able to give us information about people's needs and preferences which showed they knew people well. They were also able to give examples of how they respected people's dignity.

The registered manager told us that one of the service's strengths was ensuring people received the same small group of staff for their care visits. People and their relatives had mixed views about this. Their comments included, "They are very rarely the same carers. They don't seem to last long" and "They do change quite often but are all very nice." Some relatives told us of having the same staff attend, for example, "They are usually the same carers," but one relative said, "I don't know who is coming, the office do try to send one carer who is familiar but the cover is not adequate."

When we checked care visit schedules and care visit records, we found that people usually received the same set of care staff. This helped positive relationships to develop where staff knew people's needs and preferences, and people received familiar staff. One particular person was identified by the agency as needing consistent staffing due to communication difficulties. Records showed that they were attended to by one of two specific staff members for each of their four daily visits across two recent weeks.

We saw that the recent surveys of people using the service had three replies saying that their views and preferences about the service were not encouraged, compared to four replies stating that these were encouraged. There was a plan to address this, by ensuring people's preferences were within their care plans, which we saw was the occurring as plans were becoming more individualised.

Is the service responsive?

Our findings

There were mixed views from people and their relatives on the punctuality of visits, and about being kept informed of staff running late. Comments included, "They will call if they are late", "Care staff are usually on time", "If they're late the carers don't call. The office don't call either. Sometimes they can be an hour late" and "They are very unreliable and practically late all the time." We noted that the provider's late and missed visits policy stated that the person receiving the service would be informed if the staff member was going to be more than 15 minutes late.

When we checked electronic call-logging records against scheduled visit times, we found that actual visit times sometimes differed by over an hour from the scheduled visit times, and that scheduled times were sometimes different from what was in the care plan.

The scheduled visit times for one person were at 0730, but visit logging records showed they tended to start between 0900 and 0930. This was not appropriately punctual.

We noted that two recent spot-checks for another person had recorded them as being dissatisfied with staff punctuality. The scheduled visit times for them matched their care plan. However, 10 of 22 recent visit log records showed them receiving visits over half an hour later, and typically two hours later for their afternoon visit.

The recent visit schedule for one person included occasions when the same staff member was assigned to undertake both parts of a double-up visit, and an occasion where the two staff for a visit together were scheduled over two hours apart. There was a record on the provider's computer system that this last case had resulted in only one staff member visiting. There were to other recent cases like that. The three cases were explained as staff being stuck in traffic. However, staff visit schedules showed that one of these other visits was the result of the staff member being allocated to visit two people at the same time. The recent visit schedule for this staff member assigned them to visit three people at the same time on three occasions, which resulted in one of the people receiving their visits almost two hours late on all three occasions.

Another staff member was assigned to visit two people at different addresses at the same time on three occasions during one recent week. Visit logging records showed that in one instance, one person received their visit half an hour early and the other an hour late, to compensate for the double-booking. There were records for both of these people expressing a preference not to receive these visits early and late respectively.

These recent staff visit schedules were not appropriate for supporting them to carry out their care delivery roles in people's homes punctually.

The evidence above demonstrates a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us they knew how to complain but had not needed to. One person said, "I have no complaints. My daughter would call straightaway if there was a problem or a concern." Relatives told us the service was responsive to questions, concerns or complaints. One relative said, "The office dealt with it and we had a meeting about it." Another relative said, "I did complain, they did listen and it has changed. I am able to talk with them if there's a problem." However, one person told us of a complaint they made that was not responded to: "They were not doing a lot about it; the office was not dealing with the complaint adequately." Someone's relative said that office staff seemed to listen, and said that they would tell the care staff, but that the care staff did not then follow instructions.

The registered manager told us that she was explaining to staff that if someone using the service was unhappy with it, this was a learning opportunity to improve the service. She added that she was not operating a blame culture. Staff told us they knew they had to report any concerns or complaints to the office so that action could be taken.

One person's family member told us they had complained about staff breaking items and medicines not being given correctly. The registered manager confirmed she was aware of the issues but that these had not been progressed as complaints. This was contrary to the provider's complaints policy, which stated: "The existence of records for complaints of an apparently minor nature is an indication of the effectiveness of the procedure, the openness of the culture of the organisation and its employees. . ." The policy also confirmed that complaints did not need to be made in writing. The family member's complaints were not handled and investigated effectively.

There were three complaints recorded in the service's complaints file since our last inspection. There were timely responses in all three cases. The service apologised where appropriate, and provided some details of the investigation findings and actions they would take. However, we noted that none of the complaint responses gave options of how to contact CQC if dissatisfied with the complaint investigation.

We came across a record of complaint in one person's file. It was dated over two months before our inspection. Office staff told us they had responded to the complaint by phone, but had not processed it as a complaint. This was despite the written document clearly stating that it was a complaint. The registered manager told us she was not aware of the complaint. This did not demonstrate an effective complaints system, in line with the provider's complaints policy.

We were subsequently sent a copy of the response to the complainant. However, it failed to address parts of the complaint, it did not communicate all relevant investigated findings to the complainant, and it did not explain why there was a delay in formally responding. The complaint was not investigated effectively.

A local authority informed us of forwarding a complaint from one person to the agency a month before our visit. The provider's investigation response did not uphold the complaint, stating that there was no evidence of the specific matter occurring. However, our checks at the inspection contradicted this, which meant that the complaint was not investigated effectively.

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

Most relatives told us that there was a care plan in place and that there were regular reviews of the care. One clarified that "we are involved with it if the needs change."

The provider had updated its needs assessment and care planning process since our last inspection so as to

better capture people's individual needs and preferences. We were shown a recently-updated needs assessment and care plan for one person. As we visited this person, we were able to tell that the assessment recognised their individual needs and preferences and the care plan was responsive to these. For example, the plan recognised the person's specific health needs, food preferences, and how the person communicated.

We found overall that the process, of ensuring that everyone had had a recent review of their care needs and therefore had an up-to-date care plan available for staff in their home, was ongoing. Where the review had taken place, we found care plans reflected people's individual needs. However, the registered manager told us that the reviews were not complete, and we found instances where the care plan in the person's home was not up-to-date.

Is the service well-led?

Our findings

Following our last inspection where we identified a number of breaches of regulations, the provider sent us an action plan outlining how these matters would be addressed and within what timescale. This inspection took place a number of weeks after the expiry of those timescales. We found that the provider had taken action as per the plan in a number of areas. However, we also found that some areas of the action plan had not been completed.

The registered manager has managed the service since the provider's registration with us. She continued to hold a nursing registration. Our discussion with her showed that she had a good knowledge of people using the service as individuals, which reflected her 'hands-on' approach well. She told us that one more office staff member was being recruited, to assist with the management of the service.

We were shown examples of changes the provider had made since our last inspection. There were new policies and templates by which to improve on service quality, for example, for staff appraisals and spot-checks. The new recruitment document helped to guide office staff about making sure sufficient checks of applicants' good character were being recorded about. There was a new care delivery booklet that staff were required to use in people's homes. The registered manager told us that it was being continuously changed based on staff feedback, so as to better enable staff to make accurate and efficient care records.

We saw recent staff meeting minutes that included some care staff attending on some occasions. The meetings were used to clarify expectations around identified risks to the service such as from our previous inspection, from implementing new systems, from an incident, and to take on board feedback from people using the service.

Most staff spoke positively of the support they received from the service. Comments included, "There's good management with a prompt response in every situation" and that office staff were more responsive now than last year.

Senior staff carried out spot checks in people's homes which included areas such as care staff conduct and presentation, punctuality, and competence in the tasks undertaken. This helped ensure that care staff were providing appropriate care that met people's needs. The registered manager told us that a learning point from a recent complaint was that she recognised that consistent spot-checks of all staff were needed regardless of length of service. She was therefore implementing a three-monthly frequency of checks for all staff. She also explained how she undertook spot-checks so that staff were not aware of her presence until well into their visit. This enabled matters such as the approach of staff towards the person to be properly checked on.

When we showed the registered manager three recent instances across ten days of the same staff member being assigned to both parts of a two-person visit for one person, she told us that it was not spotted at the time of distributing staff rosters but had since been recognised as a concern. She provided evidence of current schedules that did not have this concern, which showed that the service was taking action to

address unrealistic staff schedules and late visits to people.

We saw recent surveys from people and their representatives feeding back on a range of questions. A detailed analysis had taken place of questions under the 'Effective' heading from the ten respondents, which identified strengths such as staff competency and areas for improvement such as better helping people to access healthcare professionals. A plan was set up to make specific improvements. Staff had also now been sent similar surveys. There was ongoing work to analyse all the responses, to identify what worked well and what needed improving,

The registered manager could not show us how oversight was kept of when people were due service reviews, or when staff were due refresher training, supervisions or spot-checks. She explained that they had lost this facility when switching to a new care software package late last year, and that the data to facilitate this was currently being inputted into the new system. Whilst we recognised that most staff files showed evidence of recent spot-checks, few had evidence of supervision taking place. The delay in re-establishing oversight systems was not enabling effective governance to take place.

The registered manager told us the service always got positive feedback from people using it although she recognised that a few people raised matters of staff running late. This was evident from recent spot-check records and surveys. The provider had implemented an electronic logging system at people's homes, for staff to accurately log times of arrival and departure. This could be monitored by senior staff at the service. The registered manager told us there was weekly monitoring of the new system's use, however, there were no records of this. This was despite the provider's late and missed visits policy stating that a record of late and missed visits would be kept and reviewed by the management team for improvements.

The registered manager told us that she was able to easily send reminders to all staff electronically. Where staff were reporting any concerns, this also helped to assure them that action was being taken. We saw memos to this effect, including in respect of concerns we fed back at the end of our first day of this inspection. However, we noted that three memos across the last two months essentially required the same improvement from staff about using the new electronic call-logging system. The provider could not demonstrate improvements to us in this respect, and records provided to us of the two weeks preceding our first visit showed that staff logged in or out at people's homes only 55% of the time. The system was not being used effectively to minimise risks to the health, safety and welfare of people using the service.

One relative said, "Sometimes they will leave early. There is a login system but sometimes it doesn't work. The agency should know about their carers' timekeeping." When we checked call-visit times for four people from the service's new call-logging system, we found that staff stayed 71% of the allocated time on average. This included occasions of staying less than half the allocated time. Whilst there may be occasions where the person using the service may not want the full allocated time, this average shortfall did not demonstrate care that met people's needs and preferences. Governance of call visit length, which could now be accurately monitored, was not taking place in support of minimising the risk to people's health, safety and welfare.

There were detailed audits of the recent care delivery records of two people. These were effective at identifying recording weaknesses and care delivery risks, and we saw some evidence of actions being taken in response to these such as records on the files of involved staff members about discussions to ensure improvements were made. However, the frequency and number of these audits were not yet sufficient to enable effective checks that addressed service risks. We also found that subsequent care records for the two people audited continued to contain similar concerns as those identified at audit. For example, records of repositioning one person in their bed continued not to be kept, and medicines records continued not to be

kept accurately. For the other person, most visits still had only one staff member signing the record despite two staff attending. This was despite the registered manager telling us that each involved staff member had been spoken with about what was needed, which we saw had been confirmed with a short letter to each of them.

Overall, the provider's governance processes were better at identifying risks to the health, safety and welfare of people using the service, but they were not yet effective at this, and they were not addressing identified risks.

The registered manager told us most staff had recently attended record-keeping training. This included recording more accurately and comprehensively about the care visits, such as how they found the person was on arrival, along with accurate arrival and departure times.

However, we found that care delivery records were not consistently accurate and complete, which undermines the ability of the provider to undertake governance effectively. Where one person had a visit logged as four minutes long as the second of two scheduled staff members was running late, the care delivery record made no mention of this and recorded the visit lasting the full 45 minutes. Checks of ten consecutive visit logs for this person against written care delivery records found staff recording visit times in seven cases as being more than ten minutes different to the electronic visit record. Another person was being supported by staff to eat and drink, however a week's worth of recent care delivery records did not clarify what food and drink they had been provided with and how much they ate.

The registered manager told us that if people phoned the office about anything, for example, if running late or to cancel visits, it was documented onto the provider's computer system. We found a record in one person's care delivery notes of phoning the office to report a concern, but it was not documented on the computer system so there was no record of action taking place in response. There was no such record for the concerns raised by another person's family member about the care received which the registered manager agreed she had been informed of. This was not accurate maintenance of records for the management of the service.

The registered manager told us that she had spot-checked a new staff member, however, she had not yet written the document, over ten days later. Their name was not included in the list of active care staff, despite the registered manager confirming that they were currently working. We also noted that a recent safeguarding case was not included in the provider's safeguarding file. This was not accurate maintenance of records for the management of the service.

The evidence above demonstrates 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

Enforcement actions

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Personal care	
Treatment of disease, disorder or injury	Care of service users was not provided in a consistently safe way. This included failure to: • Assess the risks to the health and safety of service users of receiving care; • Do all that is reasonably practicable to mitigate any such risks; • Ensure the proper and safe management of medicines. Regulation 12(1)(2)(a)(b)(g)

The enforcement action we took:

We imposed a condition on the registered provider's registration requiring them to send us monthly reports about their audits of service users' care plans and risk assessments, complaints, and missed or late visits, and what action was being taken to address any risks identified in those audits.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints
Personal care	
Treatment of disease, disorder or injury	The registered person 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 imposed a condition on the registered provider's registration requiring them to send us monthly reports about their audits of service users' care plans and risk assessments, complaints, and missed or late visits, and what action was being taken to address any risks identified in those audits.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA RA Regulations 2014 Good governance
Personal care	
Treatment of disease, disorder or injury	Systems were not effectively operated to ensure compliance with the Fundamental Standards. This included failure 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 and in relation to management of the service.
- Regulation 17(1)(2)(a)(b)(c)(d)(ii)(e)

The enforcement action we took:

We imposed a condition on the registered provider's registration requiring them to send us monthly reports about their audits of service users' care plans and risk assessments, complaints, and missed or late visits, and what action was being taken to address any risks identified in those audits.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 18 HSCA RA Regulations 2014 Staffing
Personal care	Persons employed by the service provider in the provision of a regulated activity did not receive such appropriate support, training and supervision as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18(2)(a)
Treatment of disease, disorder or injury	

The enforcement action we took:

We imposed a condition on the registered provider's registration requiring them to send us monthly reports about their audits of service users' care plans and risk assessments, complaints, and missed or late visits, and what action was being taken to address any risks identified in those audits.