Eleanor Nursing and Social Care Limited

Ealing Office

Inspection report

Eleanor Nursing and Social Care Limited
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**
Is the service responsive?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Ealing Office is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. The majority of people had their care funded by either London Borough of Ealing or London Borough of Hounslow. At the time of our inspection 128 people were using the service. 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. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
During the inspection we found risk assessments were not always undertaken where risks were identified for people, and where there were risk assessments these did not always record enough detail to provide staff with the relevant guidance to provide a safe level of care. Additionally, we identified people were not always having their calls at the agreed times and in some cases, there were missed calls.

Safe recruitment procedures were not always followed, as not all employment references were followed up. We were not assured the provider was following safe infection prevention and control procedures, particularly around the use of personal protective equipment (PPE).

Care plans were not always person centred and did not always provide consistent information. For example, the mental capacity section of two out of eight people's care plans provided conflicting information, so it was not clear if the people did or did not have capacity or if someone else was authorised to legally act on their behalf.

The provider did not have effective systems in place to monitor, manage and improve service delivery and to improve the care and support provided to people.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 15 May 2019) and there were five breaches of regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
This targeted inspection was prompted in part due to our ongoing concerns about late or missed care calls by the provider. We also checked whether the provider was meeting the regulations we found them to be in breach of at the March 2019 inspection. These included Regulations 9 (Person centred care), 12 (Safe care and treatment),17 (Good governance) and 19 (Fit and Proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities). Additionally, we checked if Regulation 18 (Notifications of other

incidents) of the Registration Regulations 2009 had been met. The overall rating for the service has not changed following this targeted inspection and remains requires improvement.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ealing Office on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to person centred care, safe care and treatment, recruitment and good governance. Please see the action we have told the provider totake at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service effective?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service responsive?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Ealing Office

Detailed findings

Background to this inspection

The inspection
This targeted inspection was prompted in part due to our ongoing concerns about late or missed care calls by the provider. We also checked whether the provider was meeting the regulations we found them to be in breach of at the March 2019 inspection. These included Regulations 9 (Person centred care), 12 (Safe care and treatment),17 (Good governance) and 19 (Fit and Proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities). Additionally, we checked if Regulation 18 (Notifications of other incidents) of the Registration Regulations 2009 had been met. As part of this inspection we also looked at the infection control and prevention measures in place.

Inspection team
The inspection was conducted by two inspectors and an Expert by Experience who made phone calls after the site inspection. 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 houses and flats.

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. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection, including the action plan the provider sent to us following the previous inspection saying what they would do and by when to improve. We also sought feedback from the local authorities who work with the service. 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 providers are required to send us with key information about their service, what they do well, and improvements they plan to make. We took this into account in making our judgements in this report.

During the inspection
We spoke with the registered manager and we reviewed a range of records. This included eight people's care records and multiple medicines records. A variety of records relating to the management of the service, including audits were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We also spoke with 10 people who used the service, eight relatives, five staff and one visiting professional about their experience of the service.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of the previous breaches.

Assessing risk, safety monitoring and management
At our last inspection we found risk assessments were not always robust enough and they were generic which meant they were not always person centred. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 12.

• At this inspection we found risk assessments were not always detailed enough to provide staff with guidance for safe care. One person who had a fall was seen by the occupational therapist (OT) but the care plan was not updated to indicate they were at risk of falls and did not record the recommendations of the OT. Nor was the fall recorded as an incident or accident.
• Another person's medical history listed hypertension, incontinence, diabetes, arthritis and the risk of falls but there were no risk management plans for any of these conditions.
• The care plan for one person indicated they had breathing problems, heart failure, incontinence, diabetes, falls and renal failure but there were no specific risk management plans in place around these identified areas of health needs. The care plan also recorded the person used an oxygen cylinder but there was no risk assessment for its use and no mention of it in the internal home risk assessment or as a potential fire risk. The care plan stated staff should have knowledge of oxygen cylinders, however they had not had training around the use of oxygen cylinders. The registered manager told us this was because the person was managing their own routine with the oxygen. However, for the purpose of ensuring safety, the risks around the use of oxygen cylinders were present while staff delivered care to the person and there were no plans in place about mitigating the risks.

This was a repeated breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At our last inspection we found the provider did not always follow safe recruitment procedures. This was a breach of regulation 19 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 19.

• We identified safe recruitment procedures were not always followed. We looked at five staff recruitment files and found two staff did not have employment references from their last employer and there were no recorded entries to explain how additional assurance about the staff suitability had been sought and no risk assessments to mitigate the lack of references. This meant we could not be confident the provider had done all that reasonably practicable to show that staff were always suitable to care safely for people using the service.

This was a repeated breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we also identified issues around punctuality and missed calls. At this inspection we found not enough improvement had been made.
• At this inspection we saw the local authority had identified a missed call, which the provider's systems had not. A second identified missed call by the local authority was identified by the provider but there was no evidence of what action was taken to address this shortfall. This indicated the provider's systems were not always effective in monitoring care calls which meant they could not respond appropriately to the situation.
• We also found that the actual times of calls made to people did not always reflect the time recorded in the care plan. One person's care plan stated the call time in the morning was 8-8.30am but the provider's planned time was for 7.05am and the actual time for October 2020 was between 5.50am and 7.10am. The issue with punctuality was also reflected in the other calls the person had daily. A second person's care plan stated they should have a one hour call twice a week but the registered manager confirmed they were 30 minute calls. A third person's care plan stated visits were at 9am but we saw from the daily logs, staff were calling at 6.30am. This meant that people might not have received the care they needed in a timely manner and according to their preferences.
• While some people and relatives were happy with the consistency and punctuality of calls others were not. People told us, "The carers came at 5.30pm instead of 7pm yesterday. They know I am a diabetic", "The first call is supposed to be at 9am. One Sunday, the doorbell went at 7.30am…" and "I have complained about the fact that last Saturday they didn't put anyone down to come to me." Relatives said, "At first, two months ago, we had a few carers just not showing up. So, we complained and now have regular carers during the week and different ones at weekend", "Two to three times a month we experience a difference of plus or minus two to four hours in the times of the calls" and "One month ago, on two occasions carers didn't turn up at all. The family had to put [person] to bed."

This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
• The provider had a business continuity plan regarding the outbreak of COVID-19 and an infection control policy and procedure dated October 2020. However, we were not assured the provider had robust systems in place to effectively prevent and control infections.
• The provider did not have risk assessments or risk management plans around COVID-19 for either people using the service or staff.
• There had been no additional training around infection control since the pandemic began in March 2020.
• We were told staff had undertaken training around the use of personal protective equipment (PPE) through a video link but there had been no observations of how staff put on and took off their PPE correctly. The registered manager said observations of PPE use were being completed through spot checks. However, spot

checks did not have a specific entry for measures in place for COVID-19. When we looked at five staff files to verify spot checks were being undertaken, we found none of the five staff had had a spot check in 2020. This meant we could not be assured staff were using PPE safely and effectively when providing care to people in their homes.
• Some people we spoke with told us staff did not use PPE effectively. Comments included, "I turned one carer away who turned up, hands in pockets, no mask or gloves. When asked why, they said they didn't have any" and "I have had to ask that they keep their masks on during the call before now." One relative said, "We have had some instances where the carers are not wearing their masks and have had to ask them to either leave or wear them. Sometimes they haven't had them with them to wear" but another relative said, "The carers all wear their (PPE) uniform, aprons, gloves and masks when they are working."

This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
At our last inspection we found examples of incomplete medicines administration records with gaps in signing and missing information. This was a breach of regulation 12 (Safe Care and Treatment) 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 this part of regulation 12.

• The provider had a medicines policy in place. Record keeping on the medicines administration records (MAR) had improved and the provider was now using MARs provided by the pharmacy instead of their own.
• We saw one person had not had their MAR audited, but other files we looked at had a monthly MAR audit.
• Medicines competency assessments were being undertaken to ensure staff had the skills required to manage people's medicines.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of the breaches from the previous inspection.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

At our last inspection we found people's initial assessments had not always been completed in a timely manner. At this inspection we found this remained the case.
• People's needs were assessed prior to starting the service to confirm their needs could be met by the provider. However, we saw that two people's assessments had not been completed in a timely manner which put them at risk of not getting the care they required.
• Call times identified in people's care records were not always updated on the provider's call monitoring system to reflect the times people wanted to receive their care at. This meant that people might not have received the care they needed in a timely manner.

This was a repeated breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. We checked whether the service was working within the principles of the MCA.

• At our last inspection we found mental capacity assessments were not always carried out as required. During this inspection we found information in the care plan about people's mental capacity was not always consistent, stating at different places in the mental capacity section that people had and did not have capacity.
• Two people's mental capacity assessments stated they both had permanent impairments and at the same

time full capacity. Both these people had care plans that stated they did not want their care plan shared with family and both of them had relatives who signed the care plans. It was not clear if the people had the mental capacity to make their own decisions, or if they did not, that the relatives had the legal authority to sign on their behalf.

This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of the breaches identified at the last inspection.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
At our last inspection we found people did not always have completed care plans which meant a risk that people might receive inappropriate and unsafe care and support. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 9.

During this inspection we found care plans were not always person centred so that these reflected people's current needs and preferences.
• People's care was not always personalised. In terms of involving people and relatives in planning people's care, one person said, "I have seen my care plan and I know I can talk about it with [the office staff] if I need to and they have visited" and a relative said, "I am involved in [person's] care planning meetings which look at everything." However other people told us, "I don't think I have seen a care plan, but I have a folder on the side" and "I have never had a care plan in two years."
• For one person, we saw the district nurse had left a note about pressure areas in the person's daily record of care, but there was no record of this in the care plan. This person had also had a fall but the care plan was not updated to include the risk of falls or equipment the occupational therapist recommended.
• Another person recorded medical conditions that included diabetes and allergies. However, there was no specific information regarding what allergy they had or their type of diabetes which meant staff did not have relevant information about how to provide care to meet the person's needs associated with those particular conditions.
• A third person's care plan stated staff were required to reposition the person to help prevent them from developing pressure ulcers. However, there was no guidance in the care plan about how to reposition the person and the registered manager confirmed the repositioning was not recorded. Furthermore, the personal safety section of the care plan indicated the person was bedbound and required a hoist to transfer but the moving and handling assessment stated they used a walking frame. This meant staff did not have up to date information about how to care for people in a way that met their individual needs.

The fact that people's care plans were not always person centred and detailed enough meant there was a risk they might not receive appropriate care according to their needs and preferences. This was a repeated

breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of the breaches identified at the last inspection.

Continuous learning and improving care
At our last inspection we found shortfalls regarding the governance of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 17.

• Quality assurance systems such as audits were not being operated effectively as demonstrated by a number of shortfalls identified during the inspection. These included a lack of employment references, risk assessments for people using the service and spot checks for staff.
• The care records of people using the service were audited quarterly by the audit manager. However only six service users' care records were being audited at a time which meant less than a quarter of the number of people's care records were being audited each year. Therefore, shortfalls in care records might not be noted for some time and there was no overview of the quality of care records for the whole service.
• Daily record books and MAR charts were normally audited monthly but this had not taken place for the last month of October because of staff absence. We also saw one person had not had their daily records or MARs brought into the office to be audited since they started using the service in May 2020, which meant this person's care and support might not have been monitored appropriately.
• The provider told us spot checks were being undertaken but the four staff files we looked at did not have any records of spot checks on them. We did see more recent spot checks for two other staff but there was a lack of consistency and no evidence that all staff have had spot checks in the last year.
• People's files did not always contain correct and up to date information about them. For example, in some cases information about people's mental capacity was conflicting and call times on care plans were inconsistent with the actual times people had requested for their care workers to visit.

This was a repeated breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection we found the provider did not always notify the Commission of notifications in a timely manner. This was a breach of Regulation 18 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 this part of regulation 18. The provider has sent us relevant notifications as required by law.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person did not always ensure that care was delivered to people with a view to achieving their preferences and ensuring their needs were met. Regulation 9

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person did not always seek consent for care and treatment from the relevant person and did not demonstrate they always acted in accordance with the Mental Capacity Act 2005 where a person did not have the mental capacity to make an informed decision. Regulation 11

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person did not make sure that recruitment procedures were operated effectively to ensure the suitability of each person employed to care for service users. Regulation 19

Regulated activity	Regulation

Personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The registered person did not ensure that sufficient numbers of suitably qualified, competent, skilled experienced persons were deployed to meet the needs of service users.

Regulation 18

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not always assessed or done all that was reasonably practicable to mitigate the risks to the safety of service users. Regulation 12

The enforcement action we took:

We issued a warning notice for the provider to comply with this regulation by 29 January 2021.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not always have effective systems to assess, monitor and improve the quality and safety of the service. Regulation 17

The enforcement action we took:

We issued a warning notice for the provider to comply with this regulation by 29 January 2021.