Ison Nursing Agency and Care Services Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

At our last inspection in May 2016, we found four breaches of regulations. These were about risk and medicines management, staff support and training, complaints handling and investigation, and effective governance. We imposed a condition on the provider's registration requiring them to send us monthly audit reports about care plans and risk assessments of people using the service, complaints, and missed or late visits, plus what action was being taken to address any risks identified in those audits. The provider submitted these monthly. The reports indicated that progress was being made in complying with the regulations. We undertook this comprehensive inspection to check on the progress made by the provider, and to consider whether the service could be removed from Special Measures, our framework to ensure a timely and coordinated response where we judge the standard of care to be inadequate.

The agency is registered to provide homecare services to anybody in the community. However, as a result of the service entering Special Measures following the January 2016 inspection, and remaining there since the May 2016 inspection, we imposed a condition on the provider's registration to prevent them from providing personal care to anyone new to the agency without our written permission.

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.

At the time of this inspection the agency was providing a care service to 26 people in their own homes. Whilst the provider is registered for the agency to provide nursing care to people in their own homes, the registered manager told us this was not being provided to anyone at the time of our inspection.

There was good feedback from most relatives of people using the service. They confirmed that they would recommend the service to friends and family. There was particular praise for the registered manager's responsive approach to people's care needs.

However, we found insufficient improvement in the management of the service. A number of recent staff rotas showed that staff visit scheduling tools at times allocated individual staff members to visit two people's homes at the same time which is not possible in practice.

There were occasions when electronic visit records placed the same staff member in two people's homes at the same time. We found that these records could not be trusted to ensure that staff were visiting people on time and for the full length of time.

Whilst there was some live monitoring of electronic visit records, the provider's systems were not effective at identifying and addressing risks connected to the new electronic care delivery records not being made or being written late.

People's concerns and complaints were still not always promptly and effectively investigated so as to minimise the risk of reoccurrence where appropriate. This was despite complaints audits helping to identify and address more concerns and complaints. In particular, one relative had to keep raising the level of complaint before matters were addressed. Complainants were not routinely told of how to raise concerns with independent authorities if dissatisfied with how the agency dealt with their complaint.

Records of supporting people with medicines continued to be inaccurate, and there were insufficient checks of these records by senior staff so as to identify medicines risks. We could not be assured that people were supported to receive their medicines as prescribed.

A new electronic care planning system was now in place based on detailed risk assessments, particularly for the control of infection and the management of pressure care. Care plans were accessible to staff through work-supplied phones, and so they could be easily kept up-to-date. We recognised that a lot of work had gone into setting up this system so as to better enable staff to meet people's current needs and respect their preferences.

People's relatives said staff did not rush people, and treated them respectfully and kindly. The same staff were supplied to people wherever possible. This helped positive relationships to develop where staff knew people's needs and preferences, and people received familiar staff.

People received support with nutritional and health needs, and there was evidence of good liaison with community healthcare professionals. People were supported to be involved in decisions about their care, and consent to care was appropriately sought.

Recruitment procedures made satisfactory checks of prospective new staff members' character and identity. Staff received sufficient training and support to enable them to have the skills needed to provide effective care to people. Unannounced checks of staff at people's homes were effective at identifying care delivery risks.

As a result of this inspection, enough progress had been made to address our concerns about people's safety and welfare, and so the agency was removed from Special Measures. However, there were two breaches of regulations, which are listed at the back of the full version of the report.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. Records of supporting people with medicines continued to be inaccurate and there were insufficient checks of these records by senior staff so as to identify medicines risks.

The service checked risks to service delivery in people's homes, and took action to reduce safety and care risks. This included for the control of infection and the management of pressure care.

The service had procedures for safeguarding people from abuse. Recruitment procedures made sufficient checks of prospective new staff members' character and identity.

Is the service effective?

Good

The service was effective. Staff received sufficient training and support to enable them to have the skills needed to provide effective care to people.

People received support with nutritional and health needs, and there was evidence of good liaison with community healthcare professionals.

The service was following the principles of the Mental Capacity Act 2005. People's consent to care was appropriately sought.

Is the service caring?

Good

The service was caring. Staff did not rush people, and treated them respectfully and kindly. People were supported to be involved in decisions about their care.

The same staff were supplied to people wherever possible. This helped positive relationships to develop where staff knew people's needs and preferences, and people received familiar staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. People's concerns and complaints were still not always promptly and effectively

investigated so as to minimise the risk of reoccurrence where appropriate.

However, most feedback we received indicated that people and their relatives received responsive care.

A new electronic care planning system was now in place that provided strongly individualised guidance to staff on how to meet people's needs and respect their preferences at each visit.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. There were occasions where staff visit scheduling tools and electronic visit records placed the same staff member in two people's homes at the same time. Governance systems were not identifying and addressing these concerns, which risked staff being late to people's homes and not having time to meet all care needs.

Whilst there was some live monitoring of electronic visit records, systems were not effective at identifying and addressing risks connected to care delivery records not being made or being written late.

However, there was good feedback about the management of the service, and unannounced checks of staff at people's homes were effective at identifying care delivery risks.

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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 inspection took place on 20 and 27 October 2016 and was announced. We gave the service 48 hours' notice of the inspection because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be available.

Before the inspection, we checked for any notifications made to us by the provider, any safeguarding alerts raised about people using the service, and the information we held on our database about the service and provider. This included monthly audit reports that we required the provider to send us following our May 2016 inspection.

The inspection was carried out by one inspector and a pharmacist specialist. There were 26 people receiving a service in their home, and 36 staff employed at the time of our inspection. During the inspection, we spoke with six people's relatives, four care staff, two office staff, and the registered manager. We visited one person using the service, with their permission, as part of our inspection checks, along with contacting a local authority and two community healthcare professionals for their feedback about the service.

During our visit to the office premises we looked at seven care plans for people using 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 ten staff members and records about the management of the service such as staff visit rotas, complaint records and the provider's policies. We then requested further specific information about the management of the service from the registered manager following our visits.

Requires Improvement

Is the service safe?

Our findings

At our last inspection of the service in May 2016, people using the service were not always receiving safe care. 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 care to prevent pressure ulcers.

We imposed a condition on the provider's registration requiring them to send us monthly audit reports, including for medicines management and risk assessments of people using the service. The reports were to include the action being taken to address any risks identified in those audits. The provider submitted these monthly. The reports indicated that progress was being made at addressing our previous concerns.

However, at this inspection, we found insufficient progress had been made with ensuring that people were safely supported to take medicines. This was despite positive feedback from a few people's relatives about their experience of how medicines were handled.

Medicines administration was previously recorded using handwritten medicines administration record (MAR) charts. However the provider had recently implemented a new electronic system. This enabled care workers to document when medicines had been given at the time using mobile phones supplied by the provider. We found some mistakes and discrepancies on both forms of MAR.

Both forms of MAR for one person were signed by staff to say that they had given 'zoladex oral' daily. Zoladex is an injection that was administered by district nurses every three months to this particular person, and it does not exist in an oral formulation. Therefore staff signed for this in error.

Both forms of MAR for the same person had 'buprenorphine oral' signed for by staff. Buprenorphine is a controlled drug (CD). This was signed in error, as the Registered Manager told us that the service did not take responsibility for the administration of CDs.

The MAR for another person showed doses of medicines that were supposed to be given at night time were signed by staff as given in the morning.

There were a number of gaps in the MAR that we looked at. For one person, there were missed doses of eight medicines on 2 and 3 July. The registered manager told us that the person was away on those days. However, we found care records relating to a visit that a care worker had made to this person on the 3 July. On checking the electronic call monitoring system, we saw that the person had received visits on both those days.

For another person, there were missed doses of four medicines on the 18 October and 23 October. The lunchtime doses were also missed on the 22 October and 25 October. This was noted on the electronic system.

Electronic records showed that the morning alendronic acid tablet for one person had not been signed for until corrected by staff at 18:33 on the same day. A similar case occurred the following week. As such, the administration record was not signed at the time the medicine was given, which could have resulted in a double-dose.

As a result of these errors, we were not assured that the medicines records were an accurate recording of medicines administered, and that staff preparing the MAR and staff documenting medicines administration were competent to do so.

The provider's medicines policy stated there should be regular audits of MAR. The electronic MAR enabled senior staff to see what medicines had been given, and follow-up on the same day if any doses had been missed. However, this system was not automated, and relied on an office staff member manually checking to see that all medicines doses had been given. This system was not robust, as demonstrated by the issues we identified above. As a result, we had no assurance that medicines issues were being identified and addressed in a timely manner.

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

We noted that information relating to medicines was obtained during the initial assessment visit by senior staff asking to see the person's medicines. Staff relied on the person or their representative telling them and showing them their medicines. They did not always contact relevant health professionals to get an up-to-date list of medicines. We discussed the risks relating to this with the registered manager.

There were now comprehensive risk assessments in place for each person. These included standard risk assessments applicable to everyone such as for risks associated with the care environment including fire safety and sufficient warmth. These resulted in actions such as reminding staff to check the shower temperature before supporting someone to shower. There were also person-specific assessments relating to specific care risks for the person such as for medicines, nutrition, choking, and skin integrity. These gave rise to individualised care plans that attended to safety aspects. For one person, this meant staff ensuring they supported the person to have pillows under their arms and legs after care was provided, to help minimise the risk of skin concerns developing. Risks around supporting people to move were considered and minimised, for example, through providing guidance on sling types and colours. We saw that these risk assessments were kept under review and updated, including on a monthly basis for skin integrity for some people where high risks were identified.

People's relatives raised no safety concerns, including in respect of pressure care. Their comments included, "They always check her skin, they're gentle, and there's no ulcers" and "They do say if there's any skin concerns." Staff had ensured that the person we visited had been left with pressure-relieving equipment in place. Records on people's files indicated that staff reported skin care concerns to the office so that action could be taken such as senior staff checks or requesting district nurse visits. We spoke with a community healthcare professional involved with one person who had recently had skin integrity concerns. They told us that the concerns had been addressed. This all assured us that the service was managing people's pressure care needs safely.

The service had appropriate safeguarding procedures in place. Staff told us and records confirmed that they 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, particularly about reporting it to the management team. Staff also understood the need to keep appropriate records.

For example, a relative told us of staff finding that their family member had a bruise, which they informed the relative of and made a record of. A community healthcare professional then checked it and confirmed that the person bruised easily. The registered manager told us there had been no safeguarding alerts relating to the service since our last inspection, for which we had no contradictory information.

There were enough staff employed to keep people safe and meet their needs. Records demonstrated a safe staff recruitment procedure before staff staring working in people's homes. This included an application and interview process, and checks of right-to-work documents and work histories. Copies of relevant documents were kept along with a dated statement of seeing the original. Identity checks were also made via a device that recorded results of authenticity checks such as via infrared and ultraviolet scanning. Written references and a disclosure and barring (DBS) security check were promptly taken up. There was usually a record of phoning each referee for additional checks alongside the written reference.

Attention was paid to preventing and controlling the risk of infection. Staff received certified training on this matter. A relative said that staff disposed of personal care items appropriately. People's care plans indicated good infection control standards, for example, where to find differently-coloured flannels for washing different parts of the body, and where to place them after use. Where one person had a catheter in place, their plan guided staff on how to clean around it.

Good

Is the service effective?

Our findings

At our last inspection of the service in May 2016, the service's support of staff 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, and training was not effectively provided for nutrition and pressure care awareness. The provider sent us an action plan to address these concerns.

At this inspection, we found that staff received sufficient training and support to enable them to have the skills needed to provide effective care to people. There were now records in place for where new staff had shadowed experienced staff providing care to people, as part of their training for the roles they were to perform. Where appropriate, this included observation of administering medicines to two or three people. The registered manager understood that whilst these records confirmed various practical aspects of the role that the new staff member had observed, it did not state who the staff member had visited as part of the shadowing process, which undermined the completeness of the record. The registered manager and newer staff told us new staff ordinarily followed the shadowing process by working with another staff member for people who required two staff. We saw documented evidence of this, which helped assure us that new staff were given extra support before providing care to people alone.

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. Staff confirmed that the training took place across three days. Specialist training was also provided such as dementia awareness and end of life care. The registered manager showed us the online training resource, which demonstrated the pass mark each staff member had achieved for each specific course. The service's training room contained equipment to help with practical training of staff for moving and handling, including a hoist and height-variable bed.

The registered manager told us that they had started providing staff with training in line with the new national Care Certificate via an external training agency that we found were local authority approved. We saw certificates for one of five staff who had recently completed the six-day training course. The registered manager told us she was aware of her responsibility to assess practical capability of these staff in line with the course completion requirements. However, we noted that the training did clarify that practical competency for basic life support and support to help people to move had been assessed. The registered manager told us of further specialist training that was being looked into, for example, in respect of where people had an identified choking risk. Additionally, some other staff were to be enrolled on a nationally recognised care qualification course (QCF). We saw a register for staff applications for this. The registered manager confirmed that the provider was funding these courses.

There were appraisal records for staff working for over a year. These 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 supervision policy confirmed. Most staff had recently received a supervision session, and there were ongoing plans to provide this support.

People's relatives told us of effective staffing. Comments included, "They all know what to do and they work together", "They've all got a fine understanding" and "We've two excellent regular care workers." One relative told us of the service supporting their family member to start walking again. This was in part due to the service enabling physiotherapy support to be provided.

The service supported people with health matters. People's care files had a summary of their medical history and stated what impact this might have on the proposed care. Care plans identified specific health concerns that staff had to be aware of, such as poor vision, nail care and oxygen support, along with general conditions such as Parkinson's disease. Where appropriate, staff were expected to sign for completion of health-related tasks. Action was taken where people's health raised further concerns. We saw that where someone's health needs had increased, the service had helped to ensure that greater support was provided, which the person's relative confirmed as very beneficial. In another person's case, the service was liaising with the person's representative and a community healthcare professional for monitoring the person's developing health needs. A record of one person being found on the floor recently showed that the involved staff member took prompt action to call for an ambulance.

Nutrition and hydration matters were also assessed and planned for on an individual basis. For example, one person's plan included exactly how they liked a cup of tea to be provided, along with their general meal preferences. Records of people's fluid intake and output were maintained when needed. There was also positive feedback from relatives about nutritional support, such as that staff understood the person's individual food preferences and could measure out drink thickener correctly.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. People's care files showed that the service was working in line with the principles of the MCA. There were checks of whether any formal arrangements were in place for Lasting Power of Attorney. Where the person was not immediately able to consent to care, assessment of their capacity to the decision took place. Where this deduced a lack of capacity, there were brief best-interest records that identified involvement and opinions of relevant people such as family members. In such cases, there was evidence of the person's main representative signing care plans to show involvement and agreement to the proposed care.

Records and feedback showed staff training on the principles of the MCA. A staff member told us that where anyone refused care, they tried different approaches but knew they were not to force matters. They said that ultimately refusals had to be reported to the agency.

Good

Is the service caring?

Our findings

People's relatives told us that staff were caring and respectful. Their comments included, "They're patient and considerate" and "Mum can get anxious but they're very good with her." Another relative described the regular staff "kind and conscientious", adding that they found the night staff to be awake and attentive when checked on.

People's relatives told us of staff understanding people's individual preferences. One relative told us of staff always taking the time to talk with the person, asking them "what they dreamt about" and singing songs with them. Another relative told us that if a new staff member had to attend, they were "normally" introduced by an experienced staff member.

A staff member told us about having a calm and patient approach with people using the service, and being aware that they may react differently to what's anticipated. A new staff member emphasised that they had to give people time, for example, with moving around and with eating. A relative confirmed that staff did not rush their family member and always gave "plenty of time."

People's care plans included assessment and guidance on dignity matters, and emotional and communication needs. For example, one person was unable to speak, but was facially expressive. Their plan noted the importance of providing the same staff who should therefore be better able to understand the person's non-verbal communications. It also reminded staff to still talk with the person.

People's care files demonstrated their involvement in expressing views about care decisions. People's preferred visit times were established along with checks of what was important to them, for example, in terms of family, pets, religion and communication. People were asked to sign receipt of privacy statements, to be aware of how the service looked after their personal information securely. Similarly they had the service's guide which informed them of service standards and limits along with contact details.

However, when we visited one person we found that the care plan in their home was not up-to-date. Another relative told us of not having access to an up-to-date care plan any longer. Whilst staff had direct access to the new electronic care plans, people and their relatives may not be able to easily access these on the internet via password-protected processes. The agency did not keep an up-to-date care plan available in people's homes, which we discussed with the registered manager.

A few people's relatives told us that there could be "language barriers" with the staff, although the staff had a very helpful approach. Our conversations with staff confirmed that a few had a limited understanding of English. However, records showed that these staff members usually worked with a more experienced staff member, in the homes of people who needed two staff working together. The registered manager also told us that training had been secured to help improve the spoken language skills of some staff. Recent supervision records of some staff confirmed that this was planned for them. As such, the service had identified this area of risk and was taking action to address it.

People's relatives told us that there was good staff consistency. One relative said, "It's mainly the same care workers, and they're genuine, which has helped build up rapport." Another explained that there had been too many different staff, which meant they had to explain their family member's routine each time. However, they had raised this with the agency, who had "sorted it out" and so there was now a small team of staff including replacement staff.

When we checked care visit schedules and care visit records, we found that people usually received the same small set of care staff. This helped positive relationships to develop where staff knew people's needs and preferences, and people received familiar staff.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection of the service in May 2016, complaints were not always handled and investigated effectively. Some complaints were not responded to, and investigation processes did not always address matters effectively.

We imposed a condition on the provider's registration requiring them to send us monthly audit reports, including for complaints, and the action taken to address any risks identified in those audits. The provider submitted these to us monthly. The reports indicated that progress was being made at addressing our previous concerns, as a number of complaints had been identified and there was evidence of action being taken to address the concerns. We saw that action was taken in response to some complaints. For example, where a relative had told the agency about being unhappy with a staff member turning up late too often, the staff member was subsequently removed from attending to that person.

However, when we reviewed complaints records, we found that the provider's complaints system was still not being consistently operated effectively. One complaint was not in the complaints file at either of our visits, but was found within the person's file. It was about some inaccuracies in the medicines guidance for the person. However, the complainant wrote again three weeks later asking for a reply, then phoned four more days down the line before receiving a visit that started addressing matters. Nonetheless, the complainant used the provider's formal complaints form two weeks later highlighting the lack of communication to acknowledge and resolve matters.

The provider's complaints policy 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…" However, the above complaint was not promptly addressed, contrary to the provider's policy, which caused the complainant to keep escalating it over a number of weeks until they received a response.

Following our inspection visits, the registered manager emailed us a copy of two letters to the above complainant, both dated three days after the date of the complaint form which both letters stated they were a response to. This confirmed the failure to properly respond to the complaints made in advance of using the complaints form. However, when we then spoke with the complainant, they denied receiving these letters although they said they had now had a visit from the service that resolved matters. The failure to send complaint acknowledgment and outcome letters to the complainant was contrary to the provider's policy and was not an effective response to the complaint.

The service's complaints file showed timely responses to other complaints. The service apologised where appropriate, and provided some details of the investigation findings and actions they would take. However, we noted that only one of the six complaint responses we saw gave options of how to contact CQC if dissatisfied with the complaint investigation, and four did not give information on the Local Authority Ombudsman. This was contrary to the provider's complaints policy, and so was not an effective response to complaints.

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

Most people's relatives told us of a responsive service. This included for raising concerns and for cancelling appointments. Comments included, "I've a good relationship with the manager", "We tell them of the problem and it gets fixed" and "the manager is always very willing." Another relative told us the registered manager had helped them acquire night care which enabled the relative to sleep at night. They described this as "going beyond the call of duty." One relative was happy that the care plan had been clarified to meet some specific needs but unhappy that it took too long to get to that point.

People's relatives told us that care visits were usually punctual. Typical comments included, "They try to stick to a time, and I get a text from the care worker if they're running late, which isn't often" and "The staff member told us they'd be late; we were happy to know this."

The registered manager told us that the biggest change since our last inspection was the conversion to an electronic, paperless care planning and delivery process. She explained that when staff logged attendance at anyone's home via their work phone and a device on the person's folder, their phone downloaded prompts for exactly what care had been agreed for that visit. However, staff were to also follow usual respectful processes such as checking with the person for anything else and gaining consent for care.

Our checks of people's care files showed that the new care plans were comprehensive and very specific to the person. The needs and risk assessment processes set up parts of the care plan so that staff received clear guidance on high risk matters relating to the person. The level of detail within the plans extended to exactly what was involved with, for example, brushing the person's teeth, where items such as towels could be found, and where continence pads were to be disposed of.

There were recent reviews of everyone's care needs and therefore there was an up-to-date care plan available for staff. The registered manager told us that reviews took place at least every six months, or more frequently where people's needs had changed. We saw that two people's care plans had been updated in recent weeks to reflect additional health monitoring that was agreed with them and their relative. This all helped to demonstrate individualised care planning that was helping staff to meet people's needs and preferences.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection of the service in May 2016, governance systems were not effective at reducing risks to care delivery. Systems were being developed that helped identify risks to people's welfare, but actions to address identified risks were not effective, including 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. Staff did not always receive realistic visit schedules to help them visit people punctually.

We imposed a condition on the provider's registration requiring them to send us monthly audit reports, and the action being taken to address any risks identified in those audits. The provider submitted these monthly. They provided specific detail on care planning and risk management for each person using the service, and listed what further action was needed for each person. They also identified what complaints and late visits had occurred and the action being taken to minimise the risk of reoccurrence. These reports indicated that progress was being made at addressing our previous concerns.

However, at this inspection we found that records about people's care were still not consistently accurate and complete. There was a new system of staff using their work-supplied phones to confirm that they had completed the individualised set of tasks required at each person's visits, along with making any further comments as needed. These were not always completed for people during the month of this inspection. For example, one person had two staff visiting four times a day, but there were no care delivery records for whole days. There was therefore no confirmation that the person had received the agreed care or if there were any concerns about their health and welfare. In other cases, care delivery records all four of the day's visits to one person were all completed at the end of the day. Staff were therefore relying on memory to document the care that was provided up to twelve hours beforehand. There would be no care delivery records for anyone to refer to if the person's health and welfare was compromised in the meantime, for example, if they needed medical treatment. We fed back examples of this to the registered manager during our second day of inspection.

Following the inspection, the registered manager emailed us to state that when the phone-logging system was introduced, "We experienced a short initial period of technical difficulties. However staff did fully complete care records. This was immediately brought to the attention of the company and has been successfully resolved and has not been an issue since." We therefore sent examples of where there continued to be incomplete care records. The registered manager's response demonstrated the ongoing failure of the service's governance systems to effectively identify incomplete care delivery records.

At our previous inspection, the provider had started to undertake care delivery record audits for each person using their service. These identified where care delivery records were incomplete, and where the records identified potential health and welfare concerns. They therefore provided useful governance. However, at this inspection, the registered manager told us that these audits had ceased, although office staff did check these live on weekdays. We saw occasions where the assigned office staff member documented phoning staff to check that care visits had occurred. However, this process had not captured whole days when care

delivery records had not been made. There were additionally no documented reviews of how well the new electronic care delivery records were being undertaken. This did not help ensure good governance of the service.

The provider's monthly complaints audits had not captured all complaints made. The agency's complaints file included three minor complaints made by one relative since our last inspection, for which there was evidence of resolving matters. However, none of these were identified within the monthly complaints audits. The audit for September 2016 did not include details of a phone call made on the last day of the month by the relative of a person using the service which had been logged on the provider's computer system as a complaint.

On our first day of visiting the agency, the complaints file did not have records relating to a number of complaints that the provider had told us about in their monthly complaints audits. This was partially rectified by the second day of visiting, although a number of complaint outcome letters along with details of investigations were still not present. Additionally, recent complaints by two people were not within that file albeit other records showed that these complaints were being addressed. This was all contrary to the provider's complaints policy which stated, "Complaints will be recorded centrally in order to identify any pattern of complaint relating to all or a group of Service Users." The complaints file was not supporting the effective governance and management of complaints.

The provider's response to one recent complaint confirmed that the staff member turned up late as alleged, as their car broke down. However, the electronic visit record showed that the staff member attended on time. This undermined the accuracy of the electronic visit records used by the provider to manage the service.

We identified a number of cases where electronic visit records indicated that staff were attending at two people's homes at the same time. The electronic visit records for one staff member indicated that they attended to two people at the same time on one occasion a few weeks before our inspection. This was despite the two people living 15 minutes' drive apart. When we later checked the staff member's visit schedule, we saw that they were also allocated to attend to the two people at the same time.

Following our inspection visits, we sent the registered manager a list of seven cases since 26 September where the electronic visit records indicated that the same staff member was attending at two people's homes at the same time, and asked for explanation. Their response was that matters such as these had been reported to the service's IT team for resolution. This was eight days after we had highlighted the first such case to them, during the second day of our inspection visit. We concluded that there was an inherent risk of inaccuracy within the electronic visit records which the provider had not identified and was not taking prompt action on to rectify matters. As such, the electronic system was not demonstrating that staff were visiting people on time and for the full length of time.

We found that staff still received unrealistic visit schedules, despite this being highlighted as a breach of regulations at our last inspection. A staff member we spoke with alerted us to this concern, telling us it could cause them to be late. When we checked three weeks of recent visit rota for seven staff who provided care to a number of people, five of the staff had cases of being scheduled to be working with two people at the same time. The other two had instances of no travel time in-between their visits.

In particular, one staff member was regularly assigned to visit people before their previous visit at another person's home had finished. On one weekday morning, they were assigned to visit six people in 2.25 hours when the total length of visits times was 4.5 hours, twice the time needed. Electronic visit records for this

period twice showed the staff member to be logged in at two people's homes at the same time.

Another staff member was assigned to visit three people at different addresses at the same time on two occasions during one recent week. Electronic visit logging records showed that on the first occasion, one person's hour long visit lasted three minutes.

A complaint was recently received via a spot-check, that a visit the previous Saturday had not taken place. It was encouraging that the spot-check process had helped to identify the complaint, however, when we looked into what had occurred, we found that the staff member had been allocated on their rota to visit the person at 09:50 for the morning support of washing, dressing and breakfast. This was much later than the person's usual time of 08:30. This was poor scheduling.

These recent staff visit schedules were not appropriate for supporting care staff to carry out their care delivery roles, of fully meeting people's individual care needs.

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

The registered manager has managed the service since the provider's registration with us. She continued to hold a nursing registration. Relatives told us that the registered manager was personal in her approach to them and their family members. Comments included that the registered manager "has good rapport", "bent over backwards to help" and "is brilliant, so kind." There was overall good feedback about the management team.

We saw that a number of people and their relatives had recently returned surveys in which the provider asked their view on the quality of the service. The registered manager told us that overall analysis of these was still to occur, but that they had been checked individually and there was little of concern to act on. We checked the surveys briefly, which confirmed the positive feedback from most people. The only obvious concern trend was that three people wanted to be contacted if staff were running late.

Staff and people's relatives told us that senior staff occasionally undertook unannounced checks of staff care and punctuality at people's homes. Records confirmed that these spot-checks included about staff conduct and presentation, competence in the tasks undertaken, and people's views of the care provided. This helped ensure that care staff were providing appropriate care that met people's needs, and that action was taken where improvements were identified as needed, for example, with having the service's identification badge for the staff member available. The registered manager told us that three-monthly checks for all staff were occurring.

Most care staff reported a positive working culture at the service. They told us they could report concerns to senior staff at the office and that they were listened to.

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 16 HSCA RA Regulations 2014 Receiving and acting on complaints 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)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 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. Regulation 17(1)(2)(a)(b)(c)