Three Sisters Care Ltd

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Inspection report

Montefoire Centre
Hanbury Street
London
E1 5HZ

Tel: 02077906057

Date of inspection visit:
25 August 2020
24 September 2020
28 September 2020

Date of publication:
18 November 2020

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Three Sisters Care Ltd is a domiciliary care agency registered to provide personal care to people living in their own homes. At the time of our inspection approximately 270 people were using the service within the London Boroughs of Tower Hamlets, Redbridge and Barking and Dagenham. 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
People and their relatives where applicable spoke positively about how care staff supported them, including their respectful and reliable approach. However, the provider had failed to make satisfactory improvements in relation to how they monitored the quality of the service.

People and their relatives also spoke positively about how staff consulted them about how they wished to be supported on a daily basis. However, as the provider did not assess people's mental capacity we could not be fully assured that people were supported to have maximum choice and control of their lives and whether staff supported them in the least restrictive way possible and in their best interests. The provider had not implemented and embedded policies and systems in the service to support this practice.

People told us they felt their care staff were trained and supported to properly meet their needs but this was not always demonstrated when we looked at safeguarding concerns and quality issues. People said they felt comfortable about making a complaint if necessary.

The provider was in the process of introducing some useful changes to how the service operated, such as the revised induction training and refresher training for all staff. However, these strategies to improve the quality of the service were implemented shortly before this inspection visit and therefore had not yet achieved the intended positive impact on the competency and confidence of care staff.

People told us they felt safe and comfortable with care staff. People received their care from a limited number of regular staff and got to know their regular care staff. Systems were in place to safely recruit staff who were suitable to work with people using care services. However, we found that people's care plans did not always contain sufficient information and guidance to enable staff to consistently promote people's safety and wellbeing.

Although systems were in place to protect people from risks to their safety, risk assessments were not always sufficiently robust. Improvements were needed to how the provider monitored the completion of medicine administration records to promote people's safety.

Staff told us they felt well supported by the provider particularly during the acute period of COVID-19 and enjoyed their roles supporting people. Care staff described how they reported any concerns about people's

safety and welfare to their line managers.

Audits were taking place to identify areas for improvement. This included an audit of care plans which showed some improvement since the last inspection.

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

Rating at last inspection
At the last inspection the service was rated as requires improvement (published 6 June 2019). There were repeated breaches of regulations 11 (Need for consent) and 17 (Good governance). The provider completed an action plan after the last inspection to show what they would do and by when to improve.

This service has been rated requires improvement for the last three consecutive inspections. At this inspection enough improvement had not been made and the provider was still in breach of regulations 11 and 17.

Why we inspected
We received concerns in relation to the safety and quality of care and support provided to people who used the service. We additionally received information of concern about how staff maintained professional boundaries. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has remained requires improvement. This is based on findings at this inspection.

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 monitor the service.

We have identified a continued breach in relation to how people's capacity to make decisions about their care and support are recorded by the provider, including clear information about whether relatives or the Court of Protection has authority to make these decisions on people's behalf. We have also identified a continued breach in relation to how the service is managed. We have issued a Warning Notice for the repeated breach of regulation 17 (Good governance) which includes the repeated breach of regulation 11 (Need for consent). We have also found a breach of regulation 12 (Safe care and treatment) as people's risk assessments were not sufficiently detailed.

We have additionally found a breach in relation to the quality of the risk assessments about people's needs and circumstances.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is

added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service and return to inspect if we receive any concerning information. We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety and meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress.

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 always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Three Sisters Care Ltd

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by two inspectors. One inspector visited the service and a second inspector conducted telephone calls to people who used the service and/or their relatives and care staff after the site visit. We were supported by a Bengali speaking interpreter for some of our calls to people and their relatives.

Service and service type
This service is a domiciliary care agency which provides personal care to people living in their own houses and flats. It provides a service for older adults and younger adults with disabilities and/or long-term health care needs.

Notice of inspection
We gave the service one hour's notice of the inspection. This was because we needed to check if it was safe and appropriate for us to proceed with an inspection site visit, in line with COVID-19 safety practices. Inspection activity started on 25 August 2020 and ended on 28 September 2020. We visited the office location on 25 August 2020.

What we did before the inspection
We reviewed the information we held about the service since the last inspection. This included notifications from the provider, safeguarding alerts and any complaints we received from people who used the service or their relatives. A notification is information about important events which the provider is required by law to send us. We also spoke with representatives of the local authority contracts monitoring team and reviewed written information they sent us.

Our planning also took account of the information provided by the registered manager during an

Emergency Support Framework (ESF) call on 21 May 2020. ESF calls help us to give targeted local advice, guidance and support to providers and care staff using a structured framework to guide conversations and help them to respond to emerging issues, and to deliver safe care which protects people's human rights. We spoke again with the provider on 18 August 2020 to update the information we held about 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 we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with the registered manager, the office manager and the chief executive officer. We looked at a selection of documents which included 17 care plans and accompanying medicine administration charts where applicable. We checked records for five staff recruitment, training and supervision, the complaints log, accident and incident forms and scheduling rotas for care staff. We also reviewed a range of documents related to the management of the service which included quality assurance audits for care plans and records for quality monitoring telephone calls and visits to people who use the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We reviewed policies and procedures in addition to other information about the service. We made calls to 30 people and spoke with six people who used the service and 18 relatives to find out their views about the standard of care and support they received. We also spoke with 12 care staff, two team leaders and a team manager.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. A regulation was not met.

Using medicines safely

- Although people who used the service and their relatives told us staff competently supported them with their medicine, we found that reliable and robust monitoring systems were not in place to ensure safe practices were consistently adhered to.
- The provider was now in the process of gathering MAR charts from people's homes for auditing purposes. We found gaps of recording by care staff or inconsistencies in all of the seven MAR charts we looked at. The provider told us they had not collected some of the MAR charts for five months due to COVID-19 risks.
- The MAR charts and accompanying daily logs we looked at showed the management team needed to closely monitor how care staff completed them. For example, we saw where a care worker had written over a designated alphabetical code for a person refusing their medicine rather than cross it out and write again the applicable correct code. This resulted in the entry being difficult to read. On another MAR chart the care worker had recorded they had given two tablets for a 'give when required' medicine but twice this was written unclearly and looked like a seven.
- We noted that a care worker inappropriately wrote on several occasions in the daily logs that they had been involved in the administration of a prescribed item given by a private carer, however there was no MAR chart or care plan instruction for care staff to support the person with medicines.
- We had also observed at the last inspection that some care staff did not demonstrate a suitable understanding of the correct terminology to use when recording in the daily logs how they had supported people with their medicines, for example whether they had prompted or assisted a person. At this inspection we found that staff were now provided with precise and clearly presented instructions about how to support people with their medicine needs.
- At the time of the inspection care staff were receiving refresher medicines training. The staff we spoke with told us they would contact the office for advice if they had questions about how to safely support people with their medicines. We noted an incident had occurred prior to this inspection where care staff incorrectly signed each day for a medicine given once a week due to incorrect instructions although they had given the correct dose. Staff did not promptly seek advice about the inconsistent instructions from the management team.

The provider did not demonstrate the ongoing use of thorough monitoring systems to check that people were safely supported with their medicine needs, which placed people at risk of harm. This was a repeated breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● Risk assessments were not always detailed enough. We noted that two people had experienced significant and detrimental risks that were not identified by the provider's own risk assessments. These concerns had been detected and reported by visiting staff from a local day centre. Their findings demonstrated failures by individual care staff and the provider to escalate concerns when people had insufficient essential basic household items and lived in hazardous unhygienic conditions that negatively impacted on their safety, personal care, comfort and dignity.
● Care staff were provided with some information about indicators of concern to observe for if a person had a urinary catheter but this was limited to checking urine output for strong smells and discolour. The care plan for a person with limited mobility did not provide suitable guidance about the risks of pressure ulcers. The daily records for a person with behaviours that challenged demonstrated that a regular care worker failed to evidence they understood the person's complex needs.

The lack of sufficient information and guidance in the risk assessments placed people at risk of avoidable harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● The provider had systems and policies in place to protect people. Staff confirmed they undertook safeguarding training and could speak with their line managers if they had any concerns about a person's safety and welfare. We spoke with staff about how they would identify and report different types of abuse and neglect and received appropriate responses. However, recent issues of concern showed that some staff had not always adhered to the principles of their safeguarding training.
● Staff stated they felt confident that the management team would respond to any concerns they raised. The registered manager notified the CQC about safeguarding concerns in line with legislation and on occasion also contacted the inspector to discuss the concern.
● People who used the service and their relatives told us they were pleased with the conduct of their regular care staff, who they regarded as trustworthy, polite and respectful. The provider was praised for ensuring continuity of care and being able to limit the number of care workers that people met, which promoted good relationships. Comments from people and relatives included, "They are always gentle and I feel very safe with my carers in my home", "All lovely, lovely people and so nice" and "I have no concerns about the honesty and kindness of the carers that look after [my family member] and nor does [family member]."

Staffing and recruitment
● The provider employed sufficient staff who were safely recruited to their positions. The staff files we looked at showed that appropriate procedures were followed to ensure prospective employees had suitable skills and backgrounds to work with people who used the service. This included checks to verify people's identity, employment history and their right to work in the UK, as well as a Disclosure and Barring Service (DBS) check which helps employers make safer recruitment decisions and helps prevent the appointment of unsuitable candidates.
● People and their relatives reported they received a reliable and punctual service, including where they needed the support of two staff working together to safely meet their needs. Comments included, "I can totally have faith in them for time keeping" and "They (care staff) are practically always on time and on the rare occasion they are running behind [my family member] gets a phone call, no problem at all." People and their relatives also told us care staff had sufficient time to properly provide their care and support.
● The provider used an electronic call monitoring system (ECM), which meant that care staff electronically logged their times of arrival and departure at people's homes. This was monitored by the provider to make sure people received their visits in line with their individual care plan contract. Care staff informed us the management team ensured they had enough time between visits for travelling between households.

● The registered manager showed us the current IT system used for scheduling staff visits, which was implemented since the previous inspection. The registered manager was confident that this was a more effective model for enabling office staff to identify any problems or absent information that could result in people experiencing a missed call.

Preventing and controlling infection

● People received their care and support from staff with appropriate training and guidance in infection prevention and control. This included information and support from the provider to assist staff to protect people and themselves in the current COVID-19 pandemic.

● Staff told us they were provided with sufficient personal protective equipment (PPE) and were able to easily access new supplies.

● People and their relatives confirmed that staff always wore PPE and followed correct practices, for example when bagging up and disposing of used continence pads. A relative commented, "My [family member] is already so frail and vulnerable to infections, all our care staff are taking the right steps to keep [family member] safe and protected at a time like this."

Learning lessons when things go wrong

● We found the provider had begun to introduce systems for analysing mistakes and learning from them, for example new staff training was developed following safeguarding concerns that evidenced staff were neglecting to observe and/or act on issues of concern. However, this approach was not implemented in a timely manner following the previous inspection and insufficient progress was demonstrated at this inspection.

● Accidents, incidents and other events were recorded and reviewed to minimise their reoccurrence. Prior to the inspection the provider informed us about an incident where staff did not adhere to expected standards of professionalism. The registered manager spoke with individual staff concerned and the benefits for all staff to undertake new mandatory training in relation to maintaining professional boundaries was recognised.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. A regulation was not met.

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.

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

At the last inspection the provider had not clearly demonstrated how they assessed whether people who used the service had the capacity to make decisions about their care and support, including whether they could give their consent to receiving personal care. We had also found that where relatives had signed care plans on people's behalf there was a lack of clear information to evidence that the relatives held Power of Attorney and therefore had the legal authority to do so. The absence of this was a repeated breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had failed to achieve sufficient improvement and was still in breach of regulation 11.

● The care plans we looked at showed that managerial and supervisory staff did not undertake assessments of people's mental capacity to make decisions when they carried out initial assessments and subsequent reviews. The provider had recorded in care plans that people had capacity, however we sometimes found conflicting information and were unable to understand how this statement was reached. For example, we noted that one person's care plan stated they had capacity which was contradicted by a local authority document held within their care file. Due to the absence of decision specific capacity assessments where required we could not be fully assured that people's care was planned and delivered in accordance with their choices, preferences and wishes.
● People were asked to sign their care plans in circumstances where they were identified by the provider as having capacity to consent to their personal care. We found that out of 10 applicable care plans only one was signed by a person who used the service. The registered manager told us it was not possible for managerial and supervisory staff to enable other people to sign their care plans between March and August 2020 due to COVID-19.
● At the last two inspections we had found that some people's care files contained consent forms and other

documents signed by people's relatives, although there was no recorded evidence that the relatives held Lasting Power of Attorney (LPA) for Health and Welfare. LPA is a legal document that lets people appoint one or more relatives or friends (known as 'attorneys') to make decisions on their behalf if they no longer have the mental capacity to do so themselves. At this inspection we noted the provider had documented where a person's relatives held LPA but had not made a copy or recorded the LPA reference number to make sure staff were liaising with the correct individual(s) with legal authority, in order to protect people's rights.
● We noted that one care plan showed that a relative had signed the consent to personal care on behalf of their family member. However, in addition to the lack of a capacity assessment there was also no record to demonstrate that an LPA was in place. There was also no evidence that a best interest's discussion had taken place involving relevant health and social care professionals, the relative, a member of the provider's management and supervisory team, and where possible the person who used the service.

The provider did not present satisfactory records to demonstrate people consented to their care and where people lacked capacity to do so, consent was sought from the relevant person. This was a continued breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us that staff consulted them about how they would like to receive their care and support, and always respected their wishes. Comments from people and relatives included, "They look after me nicely, yes they will ask me if they can help me into the bathroom for my wash" and "The carers are amazing. Although [my relative] is not able to vocalise their wishes, staff will speak to [my relative] and check it is ok to provide personal care."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider did not consistently ensure that people's care and support was provided in line with current standards and recognised good practice. The provider had not monitored the quality of care and support delivered to people for five months following the onset of the COVID-19 pandemic. The provider was now visiting people in their homes to check whether their needs had changed and they required new assessments.
● The care plans we looked at demonstrated the provider had appropriately considered the local authority assessment carried out by people's social workers and ensured that key information and instructions were transferred into the care plan available for staff, people and their chosen representatives.
● The people and relatives we spoke with confirmed they had been involved in their assessments and had been asked about their daily routines, likes and dislikes and how they wished to be supported. This included whether they would like to receive personal care from a care worker of their own gender.

Staff support: induction, training, skills and experience
● At the last inspection we had found that although there was a training programme in place, we spoke with care staff who did not demonstrate an acceptable understanding of how to support people living with dementia and what is meant by mental capacity. At this inspection we found that the provider's aim for improving the quality of the training and staff support was still at an early stage and had not been fully implemented.
● The provider informed us about new and compulsory training for all care staff which had commenced. In addition to revised induction training for new staff, there was a three day refresher training course which covered all mandatory training topics. This included health and safety, moving and handling and safeguarding. Additionally, staff were required to undertake online training which included understanding dementia care and mental capacity.
● People and their relatives told us care staff understood how to meet their needs. The care staff we spoke

with reported to us they were pleased their employer had introduced new training opportunities to develop their skills and knowledge. Staff also told us they felt supported by their line managers through telephone supervision during the height of the COVID-19 pandemic and now through one to one supervision sessions conducted in person.

Supporting people to eat and drink enough to maintain a balanced diet

● People received suitable support from care staff to meet their nutritional and hydration needs where this formed part of their care plan.

● A relative who brought food shopping to their family member every week commented positively about the service. The regular care worker noticed essential groceries were running low, purchased these items and contacted the relative to update them, including where to locate the receipt. We noted in a safeguarding concern that expired food items had been discovered in the home of another person.

● Care plans contained valuable information about people's dietary needs, for example if they required a soft diet and/or a diet suitable for a person with diabetes. There was guidance where necessary about how to support people if they needed assistance with feeding, for example how to position people safely and comfortably.

● The daily log sheets were not always satisfactorily completed in relation to how people were supported with food preparation, eating and drinking. For example, the daily records for one person indicated they ate a limited diet that appeared to be of a 'takeaway' nature lacking in an overall balanced and nutritional approach. There were no entries recorded by care staff to evidence this concern had been identified and escalated to the management team for guidance.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● We received positive views from people and their relatives about the quality of care and support from staff, including very complimentary comments about how the input of care staff had enabled people to remain at home with complex needs in accordance with their wishes. However, two safeguarding concerns and separate quality monitoring concerns identified by the local authority demonstrated the provider did not always work effectively with external individuals and organisations to support people to access healthcare services and other essential services they needed. The provider had introduced measures to address this, including new training for staff.

● The people and relatives we spoke with mainly stated they were able to independently contact healthcare services as required. Staff told us they spoke with people and any relatives present if they noticed a health care concern, for example if a person had developed a rash and/or their skin appeared sore. Staff stated they also documented their observations and informed their line manager, so that the provider could make sure people received appropriate healthcare support from relevant professionals.

● The provider advised people at the beginning of COVID-19 about support they might be eligible for from statutory and voluntary organisations and how to access it. For example, how to obtain befriending support and/or food packages in their local area.

Inadequate

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. This service has been rated requires improvement for the last three consecutive comprehensive inspections. The provider has failed to demonstrate an adequate level of improvement in the overall rating of the service, although elements of progress had been achieved by managers appointed since the previous inspection. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

●At our last inspection the provider did not demonstrate there were sufficiently robust systems in place to monitor the safety and quality of the service. This was a breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection we found the provider had failed to achieve sufficient improvement and was still in breach of regulation 17. This included the provider not properly addressing the continued breach of regulation 11 in relation to mental capacity assessments and appropriate documentation.

● Prior to this inspection we were contacted by the provider to state had not undertaken sufficient measures to ensure the safety of people during the particularly acute phase of the COVID-19 pandemic. The provider had ceased quality monitoring 'spot check' visits to people's homes by members of the managerial and supervisory team, in order to minimise the physical contact people and their relatives where applicable had with external parties. However, the provider had also stopped arrangements for collecting the monthly log books and medicine administration records from people's homes, which resulted in the provider not being able to robustly check that staff had delivered appropriate care and support in line with people's agreed care plans. There was no plan developed at the time to mitigate the risk of not collecting and checking these records.

● At our last inspection we had noted that care plans did not always contain accurate information and care was not always planned in a person-centred way. At this inspection we found the registered manager had audited care plans and identified where improvements were needed. We saw issues in care plans that needed to be addressed, for example a typing error that repeatedly stated a person liked to be on their own although their local authority assessment clearly identified they did not wish to be on their own. Another person's care plan identified they needed cream applied after personal care on their morning visit only, however the person received personal care to manage their continence needs on other visits during the day.

●There were also issues in relation to the quality of risk assessments which had not been identified by quality monitoring and addressed.

Due to the lack of effectual processes in place to capably monitor the quality of the service the provider was

still in breach of regulation 17 (Good governance) 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; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● At the time of the last inspection the service did not have a registered manager in post. We noted at this inspection that the provider had appointed a new manager in September 2019 who had subsequently registered with CQC, and also a new chief executive officer commenced at the service in April 2020.

● We observed that some limited improvements had been achieved since the last inspection The provider had recently introduced a new system to enable care staff to electronically record the care and support given to people in 'real time' on their work mobile phones.

● The provider had developed an improvement plan which included additional training and development for staff working in managerial and supervisory roles.

● The provider informed CQC of notifiable events, for example safeguarding events, in accordance with legislation and audited its own performance in this area. We noted there were transparent systems in place for investigating complaints and concerns from people who used the service, which included identifying any learning from mistakes where applicable.

● We noted occasions when the provider acted with openness and honesty, for example by contacting CQC to advise us of specific complaints from relatives and by informing us of the lack of effective monitoring during the first five months of the COVID-19 pandemic.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The managerial and supervisory office team had contacted people and/or their relatives by telephone during the months they did not carry out 'spot check' visits and did not monitor the completion of daily documents by care staff. Relatives mainly stated they were pleased with this telephone support. However, the frequency of these telephone calls was variable and did not ensure that all people who used the service and their relatives felt they were regularly asked for their views.

● People who used the service and their relatives spoke favourably about the quality of their care and support, and how it constructively impacted on their wellbeing. One person told us, "I don't know what I would do without them, they were marvellous when everything was shut down and I couldn't go out, I could really rely on them." A relative said, "The carers are excellent and a great practical and emotional support to us as a family as well as [my family member]."

● Staff told us they felt well supported by the provider, particularly during the height of the COVID-19 pandemic. Staff commented that they felt able to speak with their line manager if they had concerns and felt appreciated by their employer for their loyalty and hard work. Although care staff had not been able to recently join together to attend team meetings or events as these had been paused since the onset of COVID-19, they told us morale was positive.

Working in partnership with others

● Effective partnership working with local health and social care professionals and other organisations was hindered due to the provider not monitoring daily records and MAR charts for several months, as noted following the investigations of two safeguarding concerns by the local authority. The lack of monitoring limited the provider's access to an additional source of information to help determine when it might be necessary to contact others to alert them about concerns, for example, GPs, social workers, district nurses and social workers.

● There was a noticeable difference in how care staff recorded information about people in the daily logs.

Some staff wrote in a respectful way with sufficient personalised detail, which provided helpful updates for health and social care professionals. Other daily logs were written as a list of tasks completed by care staff with no reference to the individuality of people who used the service.

● Care plans we looked at contained guidance for care staff about the roles of local professionals, for example if a district nurse regularly visited to support people with clinical needs. Care staff told us they would inform the office if they observed concerning signs and symptoms when supporting people and would also speak with district nurses and other relevant professionals if they were visiting people at the same time. However, we were aware of examples where concerns were not always shared with professionals.

● The registered manager and the chief executive officer informed us about useful relationships the provider had developed to improve the quality of care and support for people. This included ad hoc opportunities for care staff to undertake catheter care training from the NHS and new links that had developed since the onset of COVID-19, for example with local infection and prevention control specialist nurses and local charities that offered different types of assistance to people.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not do all that was reasonably practicable to assess risks and where risks were identified appropriate management plans were not always put in place to mitigate risks. 12(1)(2)(a)

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 17 HSCA RA Regulations 2014 Good governance The Registered person did not ensure a suitable system was operated to assess, monitor and improve the quality and safety of the service. The Registered Person did not ensure accurate and complete records for people unable to give consent for their care because they lack capacity to do so. Reg 17(1)(2)(3)

The enforcement action we took:

Warning Notice