Skillcare Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 20, 21, 26 and 27 April 2017. This was an unannounced inspection. This service was last inspected in November 2016 where the overall rating for this service was 'Requires Improvement' and 'Inadequate' in one key question. The service stayed in 'Special Measures.' We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures.

At the last inspection, we found that although the service had made improvements they were not sufficient, and there were three breaches of regulations in relation to safe care and treatment, acting on complaints and good governance. The provider sent us an action plan stating what improvements they were going to make. During this inspection we found that the provider had not made adequate improvements in relation to safe care and treatment, acting on complaints and good governance.

Skillcare Limited is a domiciliary care service providing personal care and support to people with a learning disability or autistic spectrum disorder, younger people and older people in their own homes. At the time of our inspection Skillcare Limited was providing care to over 60 people in their own homes in the London boroughs of Barnet, Brent and Enfield.

The service had a registered manager. 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.

We found numerous service failures; missed visits were still not recorded and lateness was still identified as a significant problem by many people who used the service and their relatives. There were several occasions where only one staff member arrived at care visits that required two staff. The electronic call monitoring system was still not working effectively and was causing staff scheduling errors. The service continued to maintain manual staff rosters but not all of them had care visit times which did not help in monitoring care visits. The service did not always keep staff rosters in the office for all geographical areas. This meant the information was not always accessible thereby risking the service to people in those areas being disrupted when there were staff emergencies and absences.

We found that the provider had not made sustainable improvements in their auditing processes. The audits that were carried out had not been effective as they did not always identify errors and gaps in daily care records, medicines administration records (MAR), and quality assurance records. People's care plans and risk assessments were not always reviewed and updated following a change in the person's needs or after accidents and incidents. The audits did not always pick up on the inconsistencies in practices and care delivery. The service did not promptly act to reduce risks following unsafe moving and handling and infection control practices that were identified during quality assurance process. The service did not always

identify risks involved in care delivery thereby putting people and staff at risk of harm.

Risk assessments were detailed but did not always include appropriate information on the management of the risks to people from ongoing health conditions. The service did not always appropriately record medicines given on MAR. Accident and incident forms did not always record the learning gained from them or the actions taken.

Staff were checked and assessed for the quality of the care provided via spot checks; these are checks that are carried out by office staff to identify if staff provided care as per care plan and arrived on time; however additional checks were not always carried out in response to concerns about staff members. Complaints identified during spot checks and through quality assurance processes were not always recorded and investigated appropriately. People told us that concerns reported to the office were not always addressed and there reoccurrences.

The provider recorded the capacity of people to consent to the care and treatment but there were gaps in consent to the care and treatment forms.

Staff demonstrated a good understanding of protecting people against abuse and their role in promptly reporting poor care and abuse. However, the service did not implement required infection control practices.

The provider generally followed appropriate recruitment procedures. Staff continued to receive regular supervision. Most staff received induction and training to provide care effectively.

People and their relatives told us they felt safe with staff and were happy with them. They said that staff were friendly and caring, and respected their dignity and privacy. Most people were happy with the support they received around nutrition and hydration needs. People were asked their views on the quality of their care.

We found that the provider was not meeting legal requirements and there were overall three repeated breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to safe care and treatment, acting on complaints, and for systems and processes to improve the quality of the services including accurate records. The service remains in 'Special Measures.'

You can see what action we told the provider to take at the back of the full version of the report. However, full information about our regulatory response to the concerns found during this inspection will be added to this report 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?

Inadequate

The service was not safe. The service did not always identify risks involved in supporting people and did not give sufficient information to staff to minimise risks. There were instances of unsafe moving and handling practices.

People and their relatives told us staff did not always arrive on time and there were records of missed visits. There were gaps in medicines administration and accident and incident records. The service was not following effective infection control practices.

Staff were able to identify abuse and knew the correct procedures to follow if they suspected any abuse or poor care.

Is the service effective?

Requires Improvement

The service was not consistently effective. Some people's consent to care documents and care agreements were incomplete. People's daily care records did not always include what they ate and drank. Most people and their relatives told us staff understood their needs, and their nutrition and hydration needs were met.

Staff understood people's right to make choices about their care. Staff received regular supervision and appraisal, and were given induction and training to enable them to support people well.

People were referred to health and social care professionals as required.

Is the service caring?

Requires Improvement

The service was not consistently caring. People told us they did not always receive same staff despite of requesting them. We observed two staff provide care in an undignified way.

People using the service and their relatives told us staff were friendly, kind and caring. People told us staff treated them with dignity and respect. Staff spoke about people in a caring manner. People's care plans captured information on their religious and cultural beliefs. Staff had a good understanding of the

importance of confidentiality.

Is the service responsive?

Inadequate

The service was not responsive. There had been a considerable increase in complaints relating to missed visits since the last inspection but the service did not demonstrate adequate learning had taken place to minimise the risk of reoccurrence of missed visits. People's care plans were not always updated when their needs changed. People's and relatives' complaints and concerns were listened to but were not always addressed.

Some care plans seen detailed people's needs, likes and dislikes in a caring way.

Is the service well-led?

Inadequate

The service was not well-led. People, their relatives and local authority told us the management of the service needed improvement. There were records of spot checks and quality assurance but there were no records of if and how the issues identified during the quality assurance process were addressed. There had been an increase in missed visits that people experienced since last inspection. The service did not have effective audits and systems to monitor the quality of the service and mitigate care delivery risks.

We found that the service did not maintain accurate records of care delivery. There were several gaps in people's medicines administration records and risk assessments, and the daily care records did not give account of how people were supported with their nutrition and hydration needs.

Staff told us the management team was approachable and that they felt informed and supported.

Skillcare Limited

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.

The inspection took place on 20, 21, 26 and 27 April 2017. This was an unannounced inspection that was carried out by three adult social care inspectors.

Prior to our inspection, we reviewed information we held about the service, including previous reports and notifications sent to us at the Care Quality Commission. A notification is information about important events which the service is required to send us by law. We also contacted local authority commissioners, integrated quality in care team and safeguarding teams about their views of the quality of care delivered by the service.

There were 70 people receiving personal care support from the service, and 50 staff, at the time of our inspection. During our visit to the office we spoke with the registered manager, deputy manager, one care coordinator, one field supervisor, and one customer relationship manager. We looked at nine care plans and six staff personnel files including recruitment, training and supervision records and staff rosters. We also reviewed people's medicines administration records (MAR) and care delivery records, the service's accidents, incidents and complaints records, safeguarding records, quality assurance surveys, and spot checks which are carried out by office staff team at people's home with their permission to check on the staff member without the staff member knowing in advance.

Following our inspection, we spoke to five people, six relatives and four care staff. We arranged to visit two people at their home with their prior consent and observed care delivery, looked at their care plans, MAR and daily care records. We also reviewed the documents that were provided by the registered manager (on our request) after the inspection. In total, we gained the views of five people, six relatives, eight staff, two commissioners and one integrated quality care team professional.

Inadequate

Is the service safe?

Our findings

At the last inspection, the service had detailed safeguarding logs and accidents and incidents records. However, we found there were no action points or learning outcomes recorded on the accident and incident log. During the last inspection, we were informed by a staff member of an incident that led to a person being hospitalised; however, there were no records of this incident in the incident logs. The registered manager then told us that in future they would ensure original copies of all accident and incident logs were kept in the office.

During this inspection, we found there were records of accident and incidents. However, the service still did not always record action points or learning outcomes in the incident log. For example, out of three incidents recorded in March 2017, one incident record where a staff member had incorrectly recorded medication and failed to report or record missed medication did not detail the 'action taken' and 'learning outcomes'. The service did not always mitigate risks following accidents and incidents. For example, the most recent incident where a person had a fall due to the bed rails collapsing and sustained a head injury and had to be admitted to hospital, the service did not carry out a bed rails risk assessment.

At the last inspection, we found that risk assessments were individualised and had identified risks to people, however, not all risk assessments detailed sufficient information and instructions for staff to minimise or mitigate the risks. The registered manager told us they would arrange refresher training on risk assessment for staff who carried out risk assessment.

During this inspection, we found the issues were still the same as at last inspection. The risks assessments were for areas such as medicines, moving and handling, environment, nutrition, falls and personal care. Although the service had detailed risk assessments for people, they did not always include sufficient information. For example, a person with type two diabetes had a diabetes risk assessment in place that gave information on how it was controlled, guidance on foot care and instructions for staff when the person's sugar levels were low, but did not give information on the person's diet and signs to look out for when blood sugar levels were high. Hence, staff were not always provided with the most up-to-date and accurate information and instructions on the risks involved in supporting people and how to minimise or mitigate those risks.

The service also did not carry out risk assessments in relation to some aspects of the care being provided. For example, people using profiling beds with bed rails did not have bed rail risk assessments. We spoke to the registered manager about this and they reassured us they would complete risk assessment for people using bed rails. Following the inspection, the registered manager sent us a blank template of bed rails risk assessment. However, a completed bed rails risk assessment of the person that had an accident due to the bed rails collapsing was not provided. One person, who smoked cigarettes in their bed in the flat, was putting themselves and others in the sheltered accommodation at high risk of fire. Although the service had worked closely with the person and the local authority to arrange for fire prevention equipment, had not carried out a fire risk assessment and hence, staff were not provided with instructions on what actions they needed to take to minimise the risk of fire. This demonstrated failures to assess the risks to the health and

safety of people using the service, in support of ensuring that they were provided with safe care.

At the last inspection, we were not able to view medicines administration records (MAR) for all the people receiving support with medicines, as the management team was not able to locate any MAR and told us they were at people's homes. The MARs we were able to view had several gaps in people's MAR, the MAR were not prepared as per the service's medication management policy, and the medication sections in the needs assessments lacked accurate information on how the person was to be supported with medicines. Following the last inspection we were sent a copy of the service's updated MAR and staff confirmed they had received training on the new MAR.

During this inspection, we found the service had not made sufficient improvements. Although the service was now preparing MAR as per the policy, and needs assessments had more information on people's individual medication needs, we found MAR were not appropriately completed and there were no records of reasons for the gaps. There were numerous occasions when staff had failed to sign that they had given the prescribed medicines from the blister pack. We saw MAR for three people and all of them had gaps and there were no explanations for any of those gaps. For example, one person's MAR were not signed on 28 occasions over a 31 day period. For another person, the MAR were not signed on 20 occasions over a 28 day period.

Staff we spoke with told us they had received training in medicines administration and felt confident in supporting people with their medicines needs. The registered manager told us they had recently provided medicines administration training to staff which also included assessing staff's competency. On one of our home visits, we observed a staff member administering medicines; we saw them give all the medicines that were in the blister pack and in the original manufacturing packs to the person before breakfast and without food. However, when we checked the MAR chart for this person we noticed that one medicine was to be given with food or just after a meal as it could cause stomach upset. This was mentioned under special instructions on the MAR. We spoke to the registered manager about this and they told us, "The staff have been lazy in following practices. I will make a note in the care plan after consulting their GP." They further said they would contact the pharmacy to ensure the medicines with special instructions were stored separately and the staff would be informed of the same so as to minimise medicines administration errors. There was a risk that the person would have continued to receive unsafe medicines support without our intervention.

Most people and their relatives told us they were happy with the support they received with medicines and that medicines were given on time. However, some relatives were not happy about the medicines management and administration time. One relative told us "…the lunch call timings I am not happy as it is too early for her medicines." Another relative told us their family member, although was able to take medicines on their own, relied on staff to give them medicines. The same person had experienced numerous missed visits which meant they were left to take medicines on their own. This person's 'medication assessment and consent' stated, "[name of the person] will overmedicate if they take their medication by themselves, and has a tendency to move it around the property…carer to administer medication and record on MAR sheet." The service failure logs and people's daily care records that were seen confirmed the person had experienced several missed visits.

On one of the home visits, we observed two staff transferring a person from bed to a wheelchair commode and back using a full body hoist. During the process of transfer we saw staff providing personal care whilst the person was still hanging in the sling. We raised this safety concern to the registered manager and they told us that the hoist should be used only for transfer and not to carry out personal care tasks, and that the staff would be send on a moving and handling refresher training. The registered manager said they had a discussion with the relative regarding the person's bedroom layout as the staff had commented on

environment being difficult to work in as the bed could not be moved. We looked at this person's latest mobility risk assessment and the sections "Does the environment pose a risk to the client" and "Environmental conditions - is there anything about the immediate environment which poses any special risks" were answered as "none". This risk assessment was completed on 11 July 2016 by the registered manager and at that time the person was using a profiling bed and a hoist. This demonstrates that the service did not identify risks and constraints involved in using the hoist and the position of the bed. We saw records of care visits to this person where only one staff member attended and carried out moving and handling tasks with the assistance of the family members, which also failed to ensure the safe care of the person.

Staff told us they were provided with personal protective equipment including uniform, gloves and aprons to prevent the spread of infection. We saw boxes of gloves left in people's homes by the management team, and people and relatives confirmed staff used personal protective equipment whilst supporting them. However, at one of the home visits, we saw two staff deliver care including personal care, changing incontinence pad, giving a person a wash, administering medicines, preparing breakfast and tidying the kitchen wearing the same pair of gloves. This failed to ensure the prevention of infection. We raised this with the registered manager and they told us the staff would be send on infection control refresher training and closely monitored through increased spot checks.

At the last inspection, people and their relatives told us they were not happy with staff's punctuality and the missed visits. The staff rosters did not include care visit times and one geographical area's staff rosters were not kept at the office. The registered manager told us that they were updating their call-logging electronic system where staff would have to scan the code at the start and finish of the care visit which would minimise scheduling errors and missed and late care visits.

During this inspection, we found that missed and late visits were still an issue and the electronic call monitoring system wasn't working. Staff rosters did not always include care visit times and the service was still not producing hard copies of staff rosters for all geographical areas. This meant if the person creating staff rosters was absent such information may not have been accessible. Thereby, disrupting care visits in case of staff absences and emergencies. People and relatives told us staff did not always attend care visits, two staff didn't always arrive together on double-up care visits on time, at times only one staff member arrived on double-up care visits, and people were not always informed if staff were running late.

We concluded the service was not delivering care and treatment in a safe way to the people using their service and the above evidence, of not assessing the risks to the health and safety of service users, and mitigating any such risks, failing to ensure staff providing care were competent, not providing the proper and safe management of medicines, and failing to ensure the prevention of infection is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke to the registered manager about the reoccurrence of the late and missed visits, and they told us, "There are still teething issues with the current call monitoring system, not changed since the last inspection; staff are still not good at accessing staff rotas on their phone." The service bought a new electronic system which would be integrated with the current call-logging electronic system. They were in the process of importing people's information onto the system and will be available to use soon. Staff we spoke with told us they had enough travel time to get to the care visits and enough time to have a break in between care visits.

We looked at staff recruitment paperwork and personnel files; most of them had completed application forms, interview notes, Disclosure and Barring Service (DBS) criminal record checks, copies of identity

documents and people's right to work checks. However, we found one staff file out of six we looked at did not have reference checks as per the provider's recruitment policy. The staff member had been working without any reference checks and did not have any induction records. We asked the registered manager about this and they told us they would find the missing documents and update us. During and following the inspection the registered manager did not provide us with this staff member's missing documents. The service did not always follow appropriate recruitment procedures to ensure staff were suitable to work with vulnerable people.

People using the service and their relatives told us they felt safe with staff. One person said, "Yes, I do feel safe with staff." A relative commented, "Oh yes, she is safe with the staff."

There was a safeguarding policy in place; it included information on what was abuse, types of abuse, staff's responsibility on reporting abuse and how to report abuse. The registered manager was aware of their responsibility of reporting any allegations of abuse to the local authority and CQC. Staff we spoke with told us they had received training in safeguarding. They were able to explain what abuse meant, different types and signs of abuse, and their role in reporting abuse and any concerns. Staff told us they would report any concerns or signs of abuse to the office.

Requires Improvement

Is the service effective?

Our findings

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.

At the last inspection, people's care plans made reference to people's capacity; however, the information was not recorded consistently throughout the care plans. We had made a recommendation for the service to seek advice and guidance from a reputable source to capture and record information on MCA, based on current practice.

At this inspection, we found sufficient improvements had not been made and the service had not followed the recommendation; people's care plans had information on whether people were able to communicate and make decisions about their care. However, we found gaps in two people's consent to care and treatment documents and the information in the care plan did not corroborate with the consent and agreement document. One person who had capacity to make decisions and was able to communicate in a written and verbal way, had a consent form and agreement that said "agrees but unable to sign." Another person's consent to care and agreement to care documents were incomplete, such as 'client's representative's name, signature and date', the agreement was not dated, did not mention what risk assessments were carried out for the person.

Staff we spoke with were able to demonstrate their understanding of people's right to make choices, and told us they gave people choices and encouraged them to make decisions. People and their relatives told us staff always asked their permission before supporting them. The registered manager told us MCA was covered in staff induction training but also provided a separate workshop sessions during staff meeting. Most staff told us they had received training on MCA, and records confirmed this.

Most people using the service and their relatives said staff knew their needs and were generally happy with the care provided by staff. One person said they were happy with the carers, that they supported her with her "personal care and hygiene needs" and they knew how to support them. Another person commented the carer assisted them with personal care and shopping needs and that the care "never lets me down." However, some people told us not all staff were effective. Their comments included, "One carer I have at the moment is very good, the other carer is not so good" and "I am happy with [name of the staff] but in trouble when other carers arrive."

The majority of people using the service and their relatives told us their nutrition and hydration needs were met. One person said, "The carers are okay, they make breakfast for me." One relative told us staff visited their family member in the morning to give them "a cup of tea and medicines." However, some relatives told us staff did not always support their family members with their dietary needs. One relative commented how their family member was not provided with an evening snack and a hot drink as per the care plan. Another

relative said, "At lunch time, I get cheese, tomatoes, cucumber and bread but staff don't give to [name of the family member], they only give [name of the family member] fruit. I don't know why they won't." Two relatives told us sometimes staff arrived earlier for the lunch call leaving not enough gap between breakfast and lunch time and hence, their family members did not eat lunch well. People that were supported with their nutrition and hydration needs, their daily care records did not always include what they ate and drank. As per people's daily care records, and people's relatives' mixed feedback, we concluded the service was not effectively supporting people with their nutrition and hydration needs.

Staff told us they felt supported by the registered manager and their supervisor. The service conducted weekly group supervision sessions which were attended by the care coordinator, the registered manager and the deputy manager. At these weekly sessions they answered staff's queries and also ran refresher training and workshops. Staff told us the meetings were helpful. Staff told us they were regularly supervised. We saw records of care staff supervision which confirmed that they were regularly supervised. Office staff told us they felt supported by the registered manager and although they were not receiving one-to-one supervision they could speak to the registered manager at any time. The registered manager told us they were in the process of scheduling bi-monthly supervision dates for office staff.

Staff told us they were happy with the training and found workshops useful. Staff told us they received sufficient training to do their job well. Staff attended a three-day induction course which was mainly delivered online and involved watching videos before they started work. The induction included training in the areas such as communication, role of health and social care worker, safeguarding, moving and handling, health and safety, and first aid. Staff also received training in medicines administration, nutrition and well-being, fire safety, food hygiene, and the principles of the person-centred approach. The service had recently conducted a workshop on medicines administration and carried out competency assessment tests.

Staff received annual refresher training. We saw the staff induction training programme and training records. The registered manager told us they were going to book specialist training sessions such as dementia with the local authority. We saw information on the training session.

People using the service and their relatives told us they did not require help with contacting health and care professionals. However, we saw records of correspondence with health and care professionals such as doctors and social workers.

Requires Improvement

Is the service caring?

Our findings

People using the service and their relatives told us staff were caring and friendly. They said staff listened to them and treated them with dignity and respect. One person told us, "They are caring and kind." Another person said, "Of course [staff] treats me with dignity and respect" and "never lets me down." Relatives' comments included, "The current staff are very caring", "Some staff are good, some are very good but some can be not so good" and "I don't see [name of the staff member] as a carer but as a family member."

Staff we spoke with told us they provided care to people in a dignified way and respected their privacy. One staff member said, "I cover people's private parts when assisting with personal care. I ask what they would like me to help them with." Another staff member commented, "I make sure curtains are drawn closed, and close the doors when providing personal care." However, on one of our home visits, we observed staff providing care in an undignified way. After gaining a prior consent of the person and their relative, we observed care delivery. We saw two staff changing the person's incontinence pad whilst the person was still hanging in the sling.

Most staff we spoke with told us they enjoyed their job and shared positive working relationships with people they cared for. However, we received mixed feedback from people regarding the continuity of staff. Some people said they mostly had the same group of staff supporting them. However, some relatives told us they had requested for the same staff team but did not always receive the same staff. Staff rotas and people's daily care records seen confirmed that people did not always receive the same staff. For example, for one person receiving double up care, their daily care records for eight days showed they were supported by 10 different staff.

People's care plans included information on their religious, cultural and spiritual beliefs and preferences. For example, one person's care plan mentioned that they were Hindu and celebrated Diwali festival. People's care plans also made reference to when they needed encouraging carrying out tasks to maintain their independence. For example, a person's care plan stated, "Encourage brushing teeth" and in another person's care plan there were instructions for staff to "encourage to wash his face and clean himself." Staff told us they promoted people's independence by encouraging them to do the things they could by themselves and respecting their choices.

Staff were able to describe the importance of confidentiality. One staff member said, "If they [people using the service] confided in me I don't disclose it to everyone, keep it to myself" unless the information revealed people were at risk of harm either to themselves or to others. People's personal and sensitive information was stored securely in lockable cupboards in the office.

Inadequate

Is the service responsive?

Our findings

At the last inspection, the service did not demonstrate that sufficient learning and mitigation had promptly taken place to minimise the risk of reoccurrence of the missed and late visits.

During this inspection we found that the service had not made sufficient improvements. The service failure log showed considerable increase in missed visits since last inspection. At the last inspection 10 missed visits and five late visits were recorded by the provider over three months. During this inspection, the service failure log showed over three months a total of 54 missed visits and three late visits. The complaints log showed in total six complaints made, mainly due to missed and late visits. Three people had complained there had been numerous occasions where one staff member arrived at double handed care visits. Out of those three people, two people's family members had to assist the staff member for care delivery. For one person it happened on 41 occasions between December 2016 and February 2017. Despite making complaints, records showed out of three, two people still experienced similar issues in March and April 2017.

The registered manager told us the reasons behind missed and late visits were the same as at last inspection, related to office scheduling errors, staff not receiving rota or staff forgetting their shift.

Most people told us they had complained about staff punctuality issues, and although they were listened to by the office staff, the issues still reoccurred. One person said they had complained about not being contacted when staff were running late, saying, "Once around two weeks ago no staff member turned up then I called the office, they were supposed to call me back but didn't." Another person said, "The communication isn't very good, don't always inform me when staff running late." Relatives' comments included, "I have asked Skillcare if they can make sure staff arrives on time. Staff member in the evening arrives anytime between 5pm to 9pm", "They don't arrive on time, evening I don't mind, morning they can be over an hour late", "The problem is [two] staff never arrive at the same time" and "Staff only come on their own but not together as per the care package."

Out of 11 people and their relatives we spoke to, 10 told us they had complained about the office not notifying them of changes to the staff attending care visits. Whilst the office sent them apologetic letters, the issues reoccurred. One relative commented they had asked the management team to change evening care visit times but the changes were not implemented. They further said, "When I have raised concerns they have been addressed on a short term basis" but reverting back to the concern.

We noticed complaints that were made during spot checks or through quality assurance surveys were not transferred to the complaint logs and there were no records of how these complaints were addressed. For example, one staff member's spot check mentioned that the person was not happy with the staff and did not find them friendly, but there were no action points to see how the service had addressed the complaint.

We looked at complaints logs and saw records of complaints and response letters. The service's complaint response letter included a summary of the investigation results, and an apology where appropriate, plus

contact details of the local authority, Local Government Ombudsman and Care Quality Commission whom people could contact to raise concerns and make complaints if they felt the need. However, we did not find any apology or response letters for missed and late visits that occurred in March 2017.

This demonstrated that necessary and proportionate action had not taken place to minimise the risk of reoccurrence of the failures identified by the complaints, namely missed and late visits, and that the service did not effectively recorded, handled and responded to complaints by people using the service and their relatives.

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

People and their relatives told us they knew how to raise concerns and complaints and felt comfortable in doing so. One person said, "I am on the phone to [name of the registered manager] or [name of the care coordinator] if not happy. They address my issues in a timely manner." One relative told us, "If not happy will call the office. It was one carer who wasn't very good but she was changed."

At the previous inspection in November 2016, we found the service had introduced a new care plan template detailing necessary information to enable staff to provide individualised care. The service was in the process of updating all the care plans. The registered manager told us going forward they would review people's care plans once a year and as and when people's needs changed.

During this inspection, we found the service had still not updated all the care plans and not all of them were as detailed; some care plans still lacked necessary information on people's needs, wishes, likes and dislikes. We found that the care plans were not regularly reviewed. For example, one person's daily care records described them requiring more assistance with their meals; however, this change of needs was not reflected in their care plan. Another person's care plan, under communication, stated they were able to able to communicate in English in a verbal and written way. However, the registered manager told us the person was no longer able to communicate in a written way and had dementia. This information was not updated in the person's care plan. The care plans were not signed by the person where possible. The registered manager told us they had updated care plans to include a section where people could sign and the service was in the process of implementing these changes.

There were some care plans that were person-centred and described people's needs, abilities, likes and dislikes in a caring way. Some care plans detailed information on people's background history, communication, personal care, transfer assistance, medication, eating and drinking, companionship, and religious and cultural needs. For example, one person's care plan mentioned they had worked as an artist and was very fond of dogs, and previously had a pet dog. People's care plans included instructions for staff to provide individualised care. For example, one person who was hearing impaired and registered blind; their care plan instructed staff to "speak loudly and clearly."

The registered manager told us the information that was gathered at initial assessment stage was then transferred into care plans. We looked at people's needs assessments which detailed information on their health and social care needs. Most people and their relatives told us staff were responsive to their needs and delivered care as per the care plan.

Inadequate

Is the service well-led?

Our findings

At the last inspection, the majority of the people and their relatives told us the management of the service had improved. Staff told us they felt well supported by the registered manager and their supervisors, and that they were enjoying their job.

The service had a registered manager in post. During this inspection, we received mixed feedback from people. Some people said they were happy with the service and their calls were returned. However, most people and relatives we spoke with commented the communication within the service and the management of the service was poor. They told us the care delivery was not consistent, and problems and issues, despite them being flagged up to the management team, kept recurring.

People had experienced the same issues for a long period and told us management were not taking sufficient actions to address those issues. Records showed there was a same group of staff who were not attending care visits on time, not attending double-up care visits together, and at times not attending care visits at all but not informing the office, plus not following safe moving and handling and infection control practices. The service failure logs recorded reasons behind missed and late visits that demonstrated same staff missing visits over three month period with similar reasons.

The provider did not take adequate actions to address staff performance issues. For example, a person had experienced numerous missed visits in November 2016 and one of the action points stated on the service failure logs was to invite staff for disciplinary meeting. We asked the registered manager if staff were called in for disciplinary meeting; the registered manager told us staff were invited for the disciplinary meeting but were not sure if the meeting had gone ahead. The registered manager told us they would inform us for definite if staff were called in for disciplinary meeting and of the outcomes. During and following the inspection we were not provided with updates or records, and so we concluded that the disciplinary process had not been followed. We found another staff member had missed care visits over a two month period but no actions were taken to address the issues. Some of the reasons recorded on the service failure logs for this staff member missing their care visits were "carer confirmed that she was covering call and did not follow procedure for non-availability on day of call", "carer unable to locate client", "carer woke up late and unable to make it to client" and "carer did not read rota properly and missed call."

Another person who received double-up visits had experienced several care visits where only one staff member arrived instead of two and so care was provided with the family member's assistance, thereby putting everyone involved at risk of harm. We asked the registered manager what actions were taken to address these concerns. They told us staff were called for disciplinary hearing and given warnings on 23 March 2017. However, during inspection we did not see records of any disciplinary hearing or written warnings. The registered manager told us, "There were quite a few things going on so haven't had time" to draft the meeting notes and written warning. They further said staff were given a written warning but these had "not been printed yet and not been put on their personnel files." Following the inspection, we were provided with copies of written warnings. However, without our intervention, we were not confident that these disciplinary processes would have been completed.

The management team told us the service regularly carried out spot checks to check if staff were delivering care as per the care plan, and to check their punctuality and safe delivery of care. We saw several records of spot checks, which recorded how staff performed the tasks and any competency issues. For example, "no aprons worn, incorrect recording of tasks and care visit timings, gaps in medicines administration records (MAR), unsafe moving and handling practices, on a double-up care visit a staff member arriving almost after the care visit was completed by another staff member."

The service did not keep records on how the issues that were identified during spot checks were addressed and did not carry out additional checks in response to concerns about staff members. For example, a person who used a profiling bed and was supported with a full body hoist had a fall on 16 April 2017. The registered manager told us the set-up of the room the person slept in was not conducive to use a hoist and the staff had commented that it was difficult to work in the environment, as the bed could not be moved from the position that it was in. A spot check carried out on 22 March 2017 identified staff had not followed safe moving and handling practices; it stated, "Client was sat at edge of bed before hoisting, this client tends to lean forward – risk of falling…client hoisted at pm visit to change pad – said client was heavy." Under 'any issues identified' was recorded "moving and handling – bed manoeuvre and client not to be hoisted for pad change." During our home visit on 27 April 2017, we observed staff following exactly the same moving and handling practices thereby putting the person at risk of harm. We asked the registered manager how the issues that were identified during spot checks were addressed; they told us staff were put on additional training and addressed during supervision sessions. This demonstrated the actions the service may have taken to address the unsafe moving and handling practices identified during spot checks were not effective based on our observation on 27 April 2017.

At the last two inspections, we found the service did not have robust data management systems and did not keep contemporaneous records of care delivery. During this inspection, we found the service had not made sufficient improvements. For example, for one person identified as being at a high risk of developing pressure ulcers, staff were instructed to reposition on each care visit and complete the repositioning chart. However, we did not see any records of repositioning charts; we checked with the management team and were told, "If they were done the charts would be with daily [care] records, if they aren't in file then they aren't being done."

During and following the inspection, we looked at people's care plans, risk assessments, care delivery records and medicines administration records (MAR). We found several gaps in people's MAR records, the daily care records did not always include what people ate and drank, plus some risk assessments lacked satisfactory information, and some risk assessments were not in place. For example, one person who had a pressure ulcer that was healing well was correctly identified as at risk of developing further pressure ulcers. Although the service carried out pressure ulcer risk assessments, there were three copies of the risk assessment in the person's care plan, only one was dated, and some sections of the form were not completed and did not fully match with the person's care plan.

At this inspection we could not look at the care plans, staff files and risk assessments audits as they were stored on a staff member's computer that the registered manager did not have access to. However, we were able to review one MAR audit which had not picked up several gaps in the MAR. There were numerous gaps in people's MAR and the service had not always picked up the inconsistent recording of care delivery in people's homes and errors in MAR. We also found that a staff member's file had no references and induction records.

During the inspection whilst carrying out a home visit we were informed by a relative of an accident their family member had experienced due to the bed rails collapsing following a care visit. The person sustained a

head injury and was admitted to hospital for two days. However, there were no records of this accident in the office or in the person's house. The registered manager stated, "The accident and incident record was not in the [accident and incidents] folder during inspection and was submitted to CQC [following inspection visits] on 26 April 2017." The accident had occurred on 16 April 2017. This meant the service did not maintain notes and records of accident's investigation in a timely manner. This all demonstrated the service did not maintain accurate, complete and contemporaneous records in relation to people's care delivery and actions taken in relation to the care provided.

At the last inspection, the service gathered feedback from people using the service and their relatives. However, they were not analysing the findings and hence, the areas of improvement were not always addressed. Following the last inspection, the register manager sent us quality assurance analysis and it demonstrated most people were happy with the service they were receiving.

During this inspection, we found the service was seeking feedback from people and their relatives, records seen confirmed this. However, the service had not analysed people's feedback to identify areas for improvement. The registered manager told us although they did not analyse and maintain records of the people's survey results they had addressed the issues that they were informed by the people and their relatives. This demonstrated failure on the service's side to record information on the actions taken to improve the quality of the care delivery based on the feedback sought from people. Most people and their relatives we spoke with told us they were contacted by the office.

There had been a considerable increase in missed visits since the last inspection but the service did not demonstrate adequate learning had taken place to minimise the risk of reoccurrence of missed and late visits.

We concluded the service lacked robust and effective management systems and processes to assess, monitor and improve the quality and safety of the care service delivery.

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

Staff told us they found the registered manager approachable and felt comfortable raising concerns and making suggestions. They said weekly staff meetings were useful and enabled them to speak to the registered manager, their supervisor and other staff. Staff told us they were well informed on matters affecting their role and people's care. Records of staff meeting minutes seen confirmed that staff had opportunities to discuss various matters affecting their roles and people's care delivery.

The registered manager told us they continued to work with local authorities to improve the services. They said the local authorities did not find the improvements satisfactory including the safeguarding procedures information in the service user guide and the ineffective electronic call monitoring system. And that they were working on implementing changes such as integrating a new electronic call monitoring system to achieve the improvements.

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 Care of people was not provided in a consistently safe way. The registered persons failed to ensure that care of people was provided in a safe way. This included failure to: * assessing the risks to the health and safety of service users of receiving the care or treatment; * doing all that is reasonably practicable to mitigate any such risks; * ensuring that persons providing care or treatment to service user have the qualifications, competence, skills and experience to do so safely; * the proper and safe management of medicines; * assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated Regulation 12(1)(2)(a)(b)(c)(g)(h)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered persons failed to in respect of any complaints received: * fully investigate and undertake necessary and proportionate action in response to any failure identified by the complaint or investigation. Regulation 16(1)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons failed to effectively operate systems 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; * accurately and completely maintain records in respect of each service user, and evaluate and improve their practice in respect of the processing of the information; * maintain securely such other records as are necessary in relation to persons employed in the carrying on of the regulated activity; * evaluate and improve their practice in respect of the processing of the information in relation to the above points Regulation 17(1)(2)(a)(b)(c)(d)(f)