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

Summary of findings

Overall summary

This inspection commenced on 22 January 2018 and was unannounced. The inspection continued on 23, 24 and 25 January 2018. This inspection was carried out to check that improvements to meet legal requirements planned by the provider after our 30 August 2017 inspection had been made. Prior to this, Skillcare Limited had been inspected in April and November 2016 and April 2017 and was placed and remained in special measures.

Skillcare Limited is a domiciliary care agency based in the London Borough of Barnet registered to provide personal care for people in their own homes who may need support around their physical or mental health and may have learning difficulties or dementia care needs. At the time of this inspection there were 36 people using the service. The majority of people's care was funded by the London Borough of Brent.

The service had a registered manager. In this report we will refer to this person as the 'provider'. 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 previously inspected Skillcare Limited on 30 August 2017 and we identified repeated breaches of legal requirements in relation to safe care and treatment (Regulation 12) and good governance (Regulation 17).

At this inspection we found that although some improvements had been made to how the service assessed risks, the provider had failed to meet regulations in relation to safe care and treatment (Regulation 12) and good governance (Regulation 17). In addition, at this inspection, we identified breaches of regulation in relation to fit and proper persons employed (Regulation 19), staffing (Regulation 18) and a failure to display ratings (Regulation 20A). The service remains rated Inadequate and in special measures.

The provider did not ensure medicines were managed safely, Medicines Administration Records were not appropriately completed, contained gaps and were not updated to reflect people's current prescribed medicines. The provider had not ensured staff were competent to handle and administer medicines.

We found that improvements had been made to how the service assessed risks to people associated with their care needs, however we found instances of identified risks not being assessed and risk assessments containing incorrect information.

There was insufficient staff effectively deployed to ensure people's care needs were met. We found instances of people not receiving their visits as per their assessed care needs. The provider did not have systems in place to ensure care visits were monitored effectively. Some care visits were scheduled to run concurrently, overlapping or without sufficient travel time.

The provider did not ensure safe staff recruitment. Not all staff had undergone appropriate recruitment checks prior to working with vulnerable people or having access to people's confidential information.

Care plans were for the most part person centred and detailed. However the provider had recently switched to a new electronic care planning system which meant that care plans had lost detail around people's needs, likes and dislikes and life histories. We found instances of care plans containing incorrect and inaccurate information.

Most people told us that felt safe with staff from Skillcare. However some people told us of frequently changing staff meant that they felt less secure than they had done previously.

Records indicated that staff had received regular training and an induction. However, we found inconsistencies with how staff received supervision and an annual appraisal.

People had their care needs assessed prior to receiving service. However we found inconsistencies in the provider's assessment process and important information obtained in the care assessment was not carried through to the persons care plan.

Most people told us staff were caring; however we were told if instances of staff not delivering care as per the person's assessed care needs.

Complaints were documented and investigated as per the provider's complaints policy.

New audits had been introduced to monitor the overall quality of the service, however they had failed to pick up issues identified at the inspection.

We received mixed feedback from people and relatives regarding the overall running of the service. Care staff spoke positively of the management team and the support they received.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. We are taking action against the provider for failing to meet regulations. Full information about CQC's regulatory responses to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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. Systems were not in place to ensure staff were recruited safely. Recruitment records were inconsistent and did not contain all required background checks and information.

There were insufficient staff deployed to ensure people received care visits as per their assessed care needs.

Improvements had been made to how the service managed risk, however not all risks posed to people had been assessed.

Medicines were not managed safely and we found errors in recording and could not be assured that all staff were competent to administer medicines.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective. Gaps and a lack of information were identified in the provider's assessment and care planning processes.

Staff received training and induction. Records documented that staff received supervision and an annual appraisal. However, these were not always personal to the staff member involved.

There were some gaps in the recording of consent for people to receive personal care. However the provider was in the process of implementing improvements.

People told us they were supported to eat and drink by care staff and people at risk of malnutrition or dehydration were monitored for food and fluid intake.

The provider had a good working relationship with health care professionals that support people using the service.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring. Most people and spoke positively of their care staff. However, we were told of instances of care staff not providing care to meet peoples

assessed care needs.

People and relatives told us of difficulties in communicating with care staff.

People told us staff supported them to maintain their privacy and dignity.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive. Care plans had recently been transferred to an electronic care management system and much of the person centred detail was lost. Older style care plans were for the most part detailed and person centred.

There were instances of care plans containing incorrect information.

The provider had a complaints process in place and people knew what to do if they wished to raise any concerns.

Is the service well-led?

Inadequate

The service was not well-led. New audits had been introduced but these did not identify concerns noted by the inspection team during the inspection.

Ratings of the last CQC inspection had not been displayed on the provider's website.

We received mixed feedback from people and relatives regarding the overall service provision.

Staff spoke positively of support they received from the provider.

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.

This inspection commenced on 22 January 2018 and was unannounced. The inspection continued on site on 23, 24 and 25 January 2018.

Before the inspection we reviewed relevant information that we had about the provider. We checked for any notifications made to us by the provider and the information we held on our database about the service and provider. Statutory notifications are pieces of information about important events which took place at the service, such as safeguarding incidents, which the provider is required to send to us by law.

This inspection was carried out by three adult social care inspectors on the first day of inspection and two inspectors for the remainder of the inspection. The inspection team was supported by two experts by experience who obtained feedback from people and relatives by telephone. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. We obtained feedback from five people and five relatives by telephone.

During the inspection, we spoke with the registered manager, compliance manager, field care supervisor and administration assistant. Following the inspection, we spoke with five care staff by telephone.

We looked at the care records for 13 people which included care plans, risk assessments, daily recording notes and medicines administration records, if applicable. We reviewed 17 staff files which included recruitment, training, supervision and appraisal records. We also reviewed other records associated with the running of the service which included quality audits, complaints and rotas.

Inadequate

Is the service safe?

Our findings

At the last inspection on 30 August 2017 the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to concerns around how medicines were safely managed and how the service assessed risks to people associated with their health and care needs.

At this inspection, we found that medicines were still not safely managed. People's use of medicines was recorded using a Medicines Administration Record (MAR). A MAR is a document showing the medicines a person has been prescribed and the recording when they have been administered. We found instances of where people had been prescribed antibiotics to treat infections, this was not always appropriately documented on a MAR chart. We found that for one person who had been prescribed antibiotics to be taken three times per day over seven days, the administration of the medicine was only entered four times in total over the seven day period and not 21 times as per the dosage instructions. We could not be assured that the person received their antibiotics as prescribed. For another person, the administration of prescribed antibiotics had not been entered on a MAR chart at all.

For people who had been prescribed a medicine to be administered using a skin patch, these medicines were not documented on a body map to provide guidance to care staff on where to apply the patch, or the requirement to rotate the application site, for example, to prevent skin irritation.

We found that where people's prescribed medicines had been discontinued, their MAR's had not always been updated to reflect this. For one person, we saw that their MAR for November 2017 had been amended by care staff after being sent from the office transcribed to remove five prescribed medicines. However their care and support plan had not been updated to reflect these changes.

'As needed' (PRN) medicines are medicines that are prescribed to people and given when required. This can include medicines that help people when they experience pain. Despite this being raised at a previous inspection, there was no PRN guidance or protocols in place to provide staff with guidance as to how and when to administer these medicines. For example, one person had been prescribed a thickener to add to liquid drinks. However, no PRN protocol was in place to provide care staff with guidance on how and when to use thickener, which was a risk to the service user who was already identified as at risk of choking if the consistency of fluids was incorrect. Following the inspection, the registered manager sent some examples of PRN protocols which they intended to implement.

We also found instances of gaps in MAR's where staff had failed to sign to say that the person's medicines had been administered; codes not being explained and recording errors on MAR's. Codes are used on a MAR to indicate when a medicine was not administered as prescribed, for example the person refused the medicine. The concerns highlighted above had not been identified in the providers auditing processes.

Following the last inspection, the registered manager informed CQC that they would arrange for a pharmacist to deliver medicines administration training to staff. On initial review of staff training records during the inspection, we were unable to establish that staff had received any medicines administration

training. We discussed our concerns with the registered manager, who, later in the inspection provided training certificates to confirm that staff had received this training. The registered manager told us that they had purchased a pharmacy training package but had not yet delivered the training. We checked whether care staff had been assessed as competent to support people with their medicines after receiving training. There was a two part medicines competency system in place whereby the staff member had an initial observation and then a follow up observation before being assessed as competent. We found out of the staff records we looked at, eight care staff had an initial observation but the follow up observation had not taken place. The provider was not following their own medicines policy in this regard, which stated that following training, staff must have had their competency assessed and be signed off as competent by the registered manager before administering medicines unsupervised. The registered manager told us and some spot check records confirmed that care staff were observed administering medicines by a senior staff member.

At this inspection we found that improvements had been made to how the service assessed risk, such as putting in place detailed risk assessments for specific health conditions and skin integrity. However, we found that there were instances of risk assessments not being in place for people with identified risks such as epilepsy or where they contained inaccurate information.

A needs assessment was an assessment completed by a member of the management team prior to commencing a care service for a person to establish if their care needs could be met by the service. For one person, their needs assessment stated that they had allergies and epilepsy. No further information was available to elaborate on the risks associated with their epilepsy or allergic status. Furthermore, the person was noted to be on a pureed diet due to choking risk, however the risk assessment in place for diabetes advised staff to provide a sandwich, biscuit or bar of chocolate if their blood sugar were to drop which could place the person at an increased risk of choking. Another person was identified to be at risk of developing pressure ulcers, however their pressure ulcer risk assessment contained no information on why the person was at risk of pressure ulcers, how staff should minimise the risk and what signs staff should look out for. Another person's mobility risk assessment stated that they had a catheter. However the registered manager confirmed that this information was incorrect. The person also had a risk assessment in place for arthritis but there was no information on how arthritis affected the person or how care staff should recognise if the person was in pain. Their risk assessment stated arthritis affected both knees but their care plan stated their whole body was affected. This was conflicting information. We also found that for risk assessments in place for people who required the use of bedrails did not explain the risks posed to the person or why the person required the bedrail or cot side in the first place. This meant we could not be certain that staff had sufficient information to guide them on how to reduce or eliminate the risk so that the people were kept safe.

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

We saw that some risk assessments were detailed and personalised to the individual risks to the person and provided guidance to staff on how to keep the person safe. Some risk assessments provided guidance for care staff to manage people's health conditions such as diabetes and Parkinson's disease. Another person's pressure ulcer risk assessment gave care staff guidance on what to look for and how to report concerns. The risk assessment also stated that the person needed to be repositioned at each visit. We saw repositioning charts had been completed to confirm this had taken place.

We established that there were significant concerns with how and when people received their care visits. Some people we spoke with told us they had no concerns with how they received their care visits. When we asked people if their care staff arrived on time, responses included, "They're near enough on time. Oh yeah", "Sometimes they are late but they let me know", "Yes the majority of times. But the two carers do not come

together for the double up" and "Not necessarily, carers come between 9.30am and 10.30am". During the inspection, it came to our attention that one person experienced two instances of one member of care staff attending for their care visits on two occasions where two care staff were required. On one of the occasions, this meant that the care staff member was unable to operate the person's hoist which meant that they were late for a scheduled medical appointment. We established that the majority of people using the service required two care staff to attend to their care visits due to their assessed care needs which included moving and handling.

We looked at how the service managed their rotas. We were advised that they had started using an electronic call monitoring system which required care staff to log on and off using an app on their mobile device. However, at the time of inspection most care staff were not using the app which made monitoring of care visits difficult. The registered manager told us that staff had initially used the app, however usage had fallen. The registered manager told us they were discussing with care staff that use of the app was mandatory. The registered manager told us that people could phone the office to advise if their care staff had not attended.

We also looked at how care staff were deployed to attend care visits. Care staff who attended care visits in pairs to support with moving and handling needs were assigned to a route which had between three and four service users allocated. Rotas made available to the inspection team for the week commencing 22 January 2018 demonstrated that care visits were regularly scheduled without travel time, with overlapping times and running concurrently. Two care staff covering a route had been allocated 16 care visits throughout the day, of these seven care visits were allocated without travel time and two care visits were scheduled to overlap by 15 minutes. On another route, two care staff were scheduled to attend 16 care visits throughout the day. Of these scheduled visits, two visits on two occasions were scheduled at the same time and one care visit overlapped by 15 minutes. The travel distance between the overlapping care visits was approximately 20 minutes by public transport. This meant that care staff would be unable to be on time for scheduled care visits.

On one day in January 2018 we saw that two care staff were covering two routes concurrently and were scheduled to be visiting four different people at 09:30am. We showed this rota to the registered manager who told us that someone else must have attended the care visits, but was unable to confirm who. The registered manager told us that before Christmas, a number of care staff went on short notice leave which impacted on rotas. However at the time of the inspection with the care staff now returned to work, we remained concerned with how care visits were scheduled.

The registered manager told us that they were recruiting for additional care staff to ensure that care visits were covered. However, this meant that people did not receive consistent care at times of their preference or to ensure they were safe.

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

We reviewed 17 staff files throughout the inspection. We could see from the records that safe recruitment procedures had not been followed. Application forms did not contain full employment history and gaps in employment had not been explored. We found that six recently recruited staff members had the same reference on file from the same referee, despite not having the referee on their application form or in their employment history. The registered manager told us that the referee was a training provider who recruited care staff from overseas to undergo training in the UK. We found that some of these references had not been obtained prior to the staff member commencing employment. Another staff member commenced

employment with the provider in August 2017. However, only one character reference was obtained in December 2017. The staff member's two most recent employers, both in the care sector were not contacted for a reference and no reason was given as to why this was the case. This meant that the provider could not ensure that care workers had the appropriate knowledge and skills to provide safe and suitable care as suitable references had not been obtained.

The provider did not have oversight of staff working in the UK on a visa, as we found that one staff member's visa had expired in December 2017. Following the inspection, the registered manager submitted evidence that the staff member could work in the UK.

Staff files contained evidence of identity checks, proof of address and disclosure and barring (DBS) checks. However, one staff member working in an administration role with access to people's care records had not undergone a DBS. Following the inspection, the registered manager told us that they had applied for a DBS for the staff member

This was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When asked if they felt safe with staff from Skillcare, most people and relatives replied yes. One person told us, "So far, yes." We received mixed feedback from relatives with one relative telling us, "Yes. We [the family] are all the time here; there is always someone at home to see things." A second relative told us, "Not always as we do not have regular carers and mum doesn't know who they are. For two/three weeks we have been getting one regular carer plus another for the double up." A second relative told us, "We have been feeling quite safe with the carers but over the past three weeks we have been sent different carers we don't know and one of them was the male manager." Staff we spoke to understood their responsibilities around safeguarding and reporting concerns. The provider had a safeguarding policy in place and procedures in place to notify CQC of concerns and outcomes.

The provider had systems in place to monitor accidents and incidents. We saw that these were recorded with actions taken to as a result. The provider monitored accidents and incidents on a monthly basis.

Care staff had full access to personal protective equipment (PPE). The provider had acquired an office space near to where care staff worked where they could pick up PPE, as required.

Requires Improvement

Is the service effective?

Our findings

We asked people and relatives if they felt that care staff were trained to support them with their care needs. Feedback was positive in this regard with one person telling us, "Yes with moving and handling." We spoke with care staff who told us they regularly received training to enable them to carry out their role. Comments received from care staff included, "Three days training" and "They give us training every month." We saw that staff completed a period of induction when they commenced employment which included training around areas such as moving and handling, first aid, medicines administration health and safety and nutrition.

The registered manager told us that they delivered training which was a mixture of classroom and online. However, we found inconsistent training records for two office based staff. One office based staff member had no documented training, despite this person being in a role where they audited care records and MAR's. We were advised that the staff member had been shown what to do by the registered manager. This was of concern, as the staff member had not received medicines training and audits seen did not identify concerns with how medicines were managed which is covered in the safe and well-led sections of this report.

Staff told us they felt supported as they received regular supervision and an annual appraisal. However, we found inconsistent records were kept to evidence they had occurred. We saw some examples of detailed supervisions, which discussed staff training needs, people they were caring for and analysis of performance. However, some supervision records seen were not detailed to the staff member involved and contained identical actions to other staff member's records of supervisions.
We saw that a number of care staff had received an annual appraisal in November 2017, in which the brief responses supplied to staff to the questions asked and actions arising from the appraisal had been very similar, if not identical. This meant that the provider was not carrying out annual appraisals in a manner which was tailored to the staff member's performance and training or development needs. We saw that one staff member after less than one month employed also had an annual appraisal at the same time. We looked at staff meeting minutes on 20 October 2017 and saw recorded, '[Registered Manager] handed all attendees copies of appraisal record dated 20/11/17.' We could not be assured that the provider was ensuring annual appraisals were being carried out as per their own appraisal policy.

Care records contained a care needs assessment which was completed by the Registered Manager or compliance manager prior to the care package commencing. We saw that the care needs assessment form assessed areas of care such as professionals involved in care, health information, care needs, medicines, eating and drinking and mobility. We found that the provider was not always completing the assessments fully and information was not included in the person's care plan afterwards. For one person, their care needs assessment detailed that they required all their food pureed and thickener added to drinks. However this was not mentioned in the person's care plan. For another person, their care needs assessment detailed that they became disorientated had depression, unstable moods and poor memory. However this was not included in their care plan. We showed our findings to the registered manager, who told us that an assessment of a person's care needs was carried out once, prior to commencement of a care package, and people's care needs were monitored at regular care review sessions with the person which was confirmed by

records seen.

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this must be made through the Court of Protection for people living in the community. If people living in their own homes are receiving restrictive care that may amount to a deprivation of their liberty, an application must be made to the Court of Protection to ensure that restrictive care is lawful and in a person's best interests.

When we last inspected the service, we found that there were some inconsistencies with how consent was gained from people. At this inspection, we found similar issues, with some consent to care forms signed by the person to indicate they consented to care and some signed by the person's relative. We discussed whether the provider had checked if the relative signing the consent form had the appropriate legal authority to do so. The field care supervisor showed us a newly developed consent form which had a section if the relative had lasting power of attorney which would be completed moving forward. Records showed that staff had received training around MCA and consent.

Most people receiving care and support required only minimal assistance with meals which included preparing a ready meal or assistance with making snacks and drinks. People's care plans detailed their food likes and dislikes. One person's care plan stated that they did not eat fish or shellfish and wanted bones removed from their chicken. People did not raise any concerns regarding the support they received with regards to food and drink. One person told us, "Yeah, of course they do, they heat up my food." A second person told us, "Carers give me all my meals." Where care staff had supported people with their meals, it had been recorded in their daily progress notes.

People were only supported with their health and medical needs where this was required. Some people had family to assist when they needed to engage with health professionals. Daily care records completed by care staff indicated where a professional such as a District Nurse or GP had been involved on that day. We ascertained that one person saw the district nurse two times per week for a significant skin condition, however the skin condition itself, cause or guidance for staff was not noted anywhere in their care records. We could not be assured that the person's care plan was updated to reflect changes to their care package following intervention from health professionals. However, we saw for another person the detailed guidance from an Occupational Therapist had been transferred to the person's care plan.

We saw that the provider had worked in partnership with external agencies, such as occupational therapists, when they had moving and handling equipment concerns. The provider had also arranged for a meal delivery service for a person who did not have support from family to liaise with other agencies. We saw that the provider had arranged for a multi-disciplinary meeting for another person to include a speech and language therapist and family member, as they had requested clarification around the person's nutrition requirements.

Requires Improvement

Is the service caring?

Our findings

Most people and their relatives were complimentary regarding the caring nature of their care staff. One person told us, "They are polite." A second person told us, "Oh yes. I get on well with the carers and they all look after my needs." A third person told us, "They are gentle and they know my condition." A relative told us, "They're doing a good job and the carers are lively and try to get him to talk. They're respectful and on time and they call him [name] which means 'grandpa' in our language." A staff member told us, "We engage them in conversation. I know what I am supposed to do. I say good morning etcetera and ask them what they want to eat."

However some feedback we received indicated that care staff did not always provide person centred care to people. A relative told us, "They tend to cut corners in personal care tasks such as not washing mums hands and face." A second relative told us, "The physio came and worked with him. It's in his care plan to be supported to take a few steps to go into the kitchen but it doesn't happen because one of the carers is too busy scribing."

We looked at compliments received by the service and saw compliments had been received from relatives which complimented the caring nature of care staff. One compliment from September 2017 stated, 'I would like to inform yourself and [compliance manager] that all the carers are a credit to Skillcare. They have been trained to a very high standard. All these carers work as a team well together.' A second compliment stated, 'Did very well and I felt very comfortable with her as my carer.'

People's communication needs were listed in their care records, such as language spoken and whether they required additional support from staff around their communication. For one person, their care plan stated, '[person] prefers to communicate verbally in English. She tends to talk to herself a lot due to the dementia. Sometimes she is unable to comprehend what has been said. Care staff must be clear and use easy day to day language to communicate with her. However, we also saw that another person's referral from the local placing authority noted that they were non-verbal but could point at objects with their fingers. However this important information was not transferred to in their care needs assessment or subsequent care plan.

A number of relatives told us that they had concerns with communication and language barriers with care staff. One relative told us, "One problem, we have two carers for double ups and the two carers sent do not speak English. I have told the office not to send the two together over four times. I spoke to the manager face to face and the next weekend he sent the two same carers. It has been going on for a while now and always at the weekends. My question is how are they trained without speaking English." A second relative told us, "Some carers can barely speak understandable English. My [relative] has dementia so can't speak." A person told us, "No I can't communicate with the two Romanian carers. It's okay if one carer is English."

We received mainly positive feedback when we asked whether people felt their dignity and privacy were respected. Most people replied, "Yes." A relative told us, "He is in the downstairs room and they close the door. They report marks on him if they see them and yes, they do cover him." A second relative told us, "That's questionable. I leave out two towels so that they can cover him with one and use the other;

sometimes I can see that only one has been used. They should keep his vest on him when they're by the window. They're okay."

People and relatives told us they were involved in planning their care. Care needs assessment documented that people and their families, where possible were involved in the process. When speaking with the registered manager, we noted that she was very knowledgeable around people's backgrounds and life stories. However we found that care plans did not always reflect this information which would help care staff get to know the person, especially if the person lived with dementia.

Care plans detailed people's cultural and religious preferences. One relative told us, "They're very good with matching [care staff] and their consistency. They're reliable and they do take on cultural stuff." People's care plans noted whether they followed a specific religion. However, we found one instance of a person's care assessment note that they were of Muslim faith, however, the information supplied by the local placing authority was that they practiced the Hindu faith.

Requires Improvement

Is the service responsive?

Our findings

On initial review of people's care and support plans, we became concerned that they were entirely task focused and lacked person centred detail. The layout for these care plans was lengthy, as each individual task and prescribed medicine was listed for every care visit. We discussed our concerns with the registered manager who told us that they had recently transferred care plans to an electronic system which resulted in a loss of much of the detail about the person and their care preferences. The registered manager showed us their previous care plan template which contained much more personalised information about the person. These care plans detailed the care tasks required at each visit but also details about the person's likes, dislikes and care preferences. One person's care plan stated that they had a stroke which affected their left side and required care staff to fully support their left side when dressing and undressing. Another person's care plan stated that the person's relative support them with oral care in the evenings, however the care plan stated that staff should check with the relative in case the person had previously had their relative's assistance, forgotten and care staff were then required to provide this assistance. The registered manager assured us that these original, more detailed care plans were in people's homes which was confirmed by staff we spoke with.

Despite seeing some detailed examples of person centred care plans, we also found instances of care plans and care records containing incorrect information and errors. For example, one person's care plan noted that they used a catheter which was incorrect. Another person's care plan stated that they had a stoma, which was incorrect. A third person was noted to have had a significant respiratory condition, however when we asked the registered manager about this, we were told that the person did not have this diagnosis.

People's care visits were documented by care staff. We found that the records kept were comprehensive and person centred with care staff recording what the person had to eat if they were being supported at a mealtime. In addition, we saw examples of care staff recording where they had concerns about a person and that they had contacted the person's GP.

We checked if the service supported people at the end of their lives. At the time of the inspection, nobody was being supported in this regard. We asked the registered manager how they worked with people and their families for advance care planning. The registered manager told us that they had a section in the care needs assessment to discuss advance care planning, however, not many people wished to discuss end of life care at that stage of assessment. The registered manager told us that they had online training available for staff if they were supporting a person at the end of their life and would support staff involved.

Feedback from people and relatives noted that they had a review meeting with the registered manager where they discussed changes to their care needs and gave feedback. One relative told us, "Yeah, they came and someone came last year to review." We saw that one person's review documented that care staff were moving from prompting their medicines to providing full support. Following this meeting, a MAR was implemented to record medicines administration.

We found that there had been concerns at previous inspections with how the provider managed complaints

which had been improved upon at the last inspection. At this inspection, we found that the provider had continued to investigate and monitor complaints. However, when we looked at the providers complaint file, we saw that the original complaint had not been filed with the investigation and response. Therefore we were initially unable to assess if the response had addressed the concerns raised in the complaint. Following the inspection, the registered manager sent copies of the original complaints. We saw that since the last inspection on 30 August 2017, seven complaints had been received and investigated by the registered manager. Four complaints related to missed visits, two regarding personal care and one regarding moving and handling and an uninvited person attending with the carer. We saw that the service sent letters to the complainants acknowledging the complaint and investigated all complaints on file. There was an outcome section at the front of each complaint that noted what the service had done to address the issue. This included, apologising to the complainant, informing them where staff were to be disciplined, re-training for staff or supervision. Many of the complaints noted that information following complaints was shared in team meetings for learning purposes. People and relatives told us that they knew how to raise a concern and felt safe to do so. One person told us, "Yes due to timing. 11am call missed, phoned the office and they sent a carer one and a half hours later." A second person told us, "Yes but I am never listened to." A relative told us, "Never had to raise a concern."

Inadequate

Is the service well-led?

Our findings

The service had been last inspected on 30 August 2017 and the inspection report had been published on the CQC website on 25 October 2017. A letter was sent to the provider with the final report informing the provider that they were required to display their rating. It is a legal requirement for providers to display the CQC performance ratings. Providers must ensure that their rating(s) are displayed conspicuously and legibly at the location delivering a regulated service and also the website. Prior to the inspection, we checked the provider's website and saw that the rating was not displayed on the provider's website. On commencement of the inspection we saw that the provider had displayed the rating of the April 2017 inspection in their office, which was changed to reflect the August 2017 inspection during the inspection.

We advised the registered manager of the requirement to also display the rating on their website and were assured that this would be actioned. Following the inspection, on 7 February 2018, the registered manager informed us that they had technical issues with their website and the rating would be displayed within seven working days. However, this had not been rectified at the time of this report.

This was in breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in August 2017, we identified that there had been improvements to how the service investigated and managed complaints. However, we found that there were continued concerns with how the service ensured medicines and risks posed to people were managed safely. At this inspection, we found that there had been some improvements to how the service assessed risk, however the level of improvement made had been insufficient. Medicines management remained a concern with both factors contributing to a repeated breach of Regulation 12. It is of particular concern that since the services first comprehensive inspection in April 2016, the provider has been in breach of this regulation through five inspections. Therefore we were not assured that the provider understood the responsibilities and requirements of being a registered service provider.

The provider was not adhering to safe staff recruitment practices. Staff were working with vulnerable adults without adequate recruitment checks in place and this potentially placed people at risk of harm but this had not been recognised by the provider. The evidence seen on inspection supported that the provider did not fully understand the regulatory requirements in relation to safe recruitment of staff. The provider's recruitment practices had been identified as a concern at an earlier inspection and although improvements had been made to the provider's recruitment processes, significant concerns were still identified at this inspection.

The provider had not ensured that there were sufficient levels of care staff deployed to ensure people received their care visits as set out in their care plans. Despite assurances given in previous inspections, the provider had not established a robust system to ensure care visits could be monitored. Rotas showed that care staff were assigned concurrent, overlapping and back to back care visits.

We discussed the management structure of the service and workload with the registered manager. At the time of the inspection, the registered manager was supported by a compliance manager who worked mainly in the field completing care visits, completing assessments and spot checks and rotas. In addition, there was an office based field care supervisor who was responsible for updating care plans and risk assessments based on information fed back by the registered manager or compliance manager. The field care supervisor also completed audits of care records and MARs. There was an administration assistant who also completed audits of care records and MARs and transferred information such as rotas to the electronic care management system. The registered manager told us that they were in the process of recruiting for a deputy manager and additional office staff. We found that the registered manager was completing many tasks such as care visits, payroll and drafting care plans and risk assessments. The registered manager told us that it had been a challenge to ensure these tasks were completed without having a deputy manager in place. The registered manager told us, "I will get a document given to me with a change. The review process needs to be more robust. I need to take the time to do it."

We discussed with the registered manager the changes they had made since the last inspection to improve how the service operated. The registered manager told us that they had started to audit every care file, reviewed peoples medicines, implement food and fluid charts for people they were concerned about and increased audits on MARs in people's homes. We saw that the registered manager had made attempts to improve how they monitored the quality of service. The registered manager had implemented an oversight of the risk assessments in place for people with certain risks associated with their health and care.

We found that there were errors and inconsistencies were noted in the care planning process during the inspection with care records containing inaccurate information and errors. Again, these concerns had not been identified in the provider's auditing processes.

The registered manager had implemented an auditing system based on the CQC key lines of enquiry which was completed on a monthly basis. This audit checked areas such as complaints, missed and late visits, accidents and incidents, safeguarding alerts, staff vacancies, recruitment and training. Actions and outcomes were then recorded against the specific area checked. For example, complaints were analysed and the outcomes were recorded with actions such as whether they commenced the disciplinary process with a staff member and whether an apology was sent to the complainant. However, we identified some gaps in how the audit tool was being used, for example, in September, October and November 2017, the registered manager stated that no references were outstanding for any staff members, when this was not the case. Also, the audit did not identify any concerns with how medicines were managed as errors identified by the inspection team had not been identified.

The above information showed that the service was failing to ensure that there was adequate oversight and governance of the service. Systems and processes were not sufficiently robust to ensure that any issues could be identified and resolved. The service had also not identified any of the issues we identified as part of this inspection.

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

We received mixed feedback from people and relatives in relation to the overall experience they had with Skillcare with some positive and some negative feedback. Comments received included, "Nothing. I'm quite satisfied", "So far, it's a good service to me and my husband" and "I'm very happy with this company. Sometimes they even drop people off. They're very reliable and we had the best Christmas service (from any other agency they've had) and "Better communication is needed between the carers, the office and

informing the family."

Staff were positive about working for Skillcare and the support they received from the registered manager and office based staff in general. One staff member told us, "[Registered Manager] is nothing but helpful. Constantly giving advice." A second staff member told us, "If I have a problem, they help me all the time. I speak to [Compliance Manager] more." A third staff member told us, "We have a really good team."

Staff meetings took place on a regular basis at a separate location used by the provider nearer to the Brent area where staff were mainly based, to ensure maximum attendance. This venue was also used to deliver training and as a base for staff to collect personal protective equipment (PPE) and paperwork. Topics discussed at meetings included CQC inspection outcomes and actions for staff to complete, the use of electronic care monitoring and supervisions and appraisals.

We asked if people were asked for feedback on the service they received. One relative told us, "Once in a while." A person told us, "I think so I can't remember." We saw that a satisfaction survey had been sent to people and relatives in January 2018, where 16 people responded, 12 of which were satisfied with the service they received. The results of the survey had not at the time of inspection been collated, analysed or shared with staff or people and relatives. We saw that a staff satisfaction survey had also been completed in September 2017 which was noted to have been mostly positive.