ICare Solutions Manchester Limited

iCare Solutions Manchester Limited

Inspection report

475 Chester Road
Manchester
Lancashire
M16 9HF

Tel: 01618820404
Website: www.icare-solutions.co.uk

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
ICare Solutions Manchester Limited is a domiciliary care agency. The service provides care and support to older adults living in their own homes in the Trafford, Manchester, Wakefield and Congleton areas.

ICare Solutions Manchester Limited also provides care and support for people referred to the Stabilise and Make Safe (SAMS) service, contracted by Trafford local authority. This service focuses on helping people regain their confidence, strength and independence following an illness, accident or hospital stay.

At the time of this inspection the service was providing care and support to 114 people. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
The registered manager or provider were not able to demonstrate improvements made to the service since the previous inspection. Systems to monitor the quality and safety of the service were either not in place or were ineffective. The provider had not identified the issues we highlighted during the inspection, such as those relating to management and oversight of the service, safe recruitment, timely care planning and use of the electronic call monitoring systems.

There was insufficient provider oversight of the service, including the two satellite hubs in Wakefield and Congleton. The registered manager of the Manchester branch was unable to devote the time needed to the Manchester service as they also assumed a regional role within the wider iCare company. Records we requested in relation to the two satellite hubs of Congleton and Wakefield were not available at the Manchester office. Where action had been taken to try and improve quality and safety of care this did not always accurately reflect the provider's policies or processes.

The provider monitored staff timeliness through electronic call monitoring. Usage of this by staff was inconsistent across all areas of the business. Where this was used, electronic call monitoring records indicated that some calls were cut short. Where people did not regularly receive their commissioned support in full, we saw no evidence that commissioners were contacted to carry out reviews of care.

Recruitment was not undertaken in a safe way. Staff received pre-employment checks prior to commencing employment, however, these were not always appropriately actioned or followed up. Actions identified to mitigate identified risks were not followed. There was not always a clear rationale documented for why the company judged a potential employee was suitable to work with vulnerable adults when potential risks had been identified.

People were receiving their medicines as prescribed. People felt the staff providing support were competent.

The provider had taken action to keep people and staff safe during the COVID-19 pandemic. The provider had shared government guidelines and other information about COVID-19 and staff had access to full personal protective equipment.

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

Rating at last inspection and update: The last rating for this service was requires improvement (published 23 January 2020) and there were three breaches of regulation. At this inspection we found improvements had not been made and the provider was still in breach of regulations.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 6, 8 and 12 November 2019. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve the breaches in person centred care, good governance and the requirement to display the rating.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements. The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.

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

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

We have identified breaches in relation to good governance, person centred care and recruitment of staff at this inspection. The provider could not demonstrate improvements since the last inspection in good governance and person centred care. For these repeat breaches in regulation we issued two warning notices which were accepted by the provider.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of

inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

iCare Solutions Manchester Limited

Detailed findings

Background to this inspection

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

Inspection team
The inspection team consisted of one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced. The provider was contacted the day before and given notice of the inspection. This was to ensure the office was open and to make arrangements in line with government measures in place because of the COVID-19 pandemic.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from four local authorities and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to

send us to give some key information about the service, what the service does well and improvements they plan to make. This information helps support our inspections.

We used all of this information to plan our inspection.

During the inspection
We spoke with 14 people who used the service and four relatives about their experience of the care provided. We spoke with 11 members of staff including the provider, registered manager, branch manager and eight care workers.

We reviewed a range of records. This included five people's care records and multiple electronic call monitoring records. We looked at six staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at call monitoring logs and quality assurance records. We asked the registered manager for information relating to two satellite offices located in other areas as records relating to these were not on site on the day of the inspection visit.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as required improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to person centred care. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 9.

- Staff were not always logging in and out of calls. We viewed call logs for November 2020 for seven people and six employees. Office staff were required on occasions, to remotely record start or finish times on behalf of care staff on the electronic call monitoring system. These entries did not always accurately reflect the time staff spent delivering care to people.
- When electronic call monitoring systems were being used correctly, it indicated some calls were being cut short of the commissioned time.
- People were not always receiving timely or appropriate care and support to meet their needs therefore, the care being provided was not always person-centred.

This was a continued breach of Regulation 9 (Person-Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Risk assessments to support the risks people presented were in place. There was an example where a care plan was not always fully completed prior to the commencement of the delivery of care.

Staffing and recruitment

- Recruitment was not undertaken in a safe way. Staff received pre-employment checks prior to commencing employment, however, these were not always appropriately actioned or followed up.
- One person had offered a DBS from a previous employment, which was two years out of date. A new application to check the person was suitable to work with vulnerable adults had not been submitted by iCare Solutions Manchester Limited.
- Risk assessments had been completed for employees with previous convictions on their DBS however, actions identified to mitigate the risks were not followed. One person was employed on the basis that additional supervision and monitoring would be completed but these had not happened.
- There was not always a clear rationale documented for why the company judged a potential employee

with previous convictions was suitable to work with vulnerable adults.

We found no evidence that people had been harmed however, systems in place to demonstrate potential employees had been safety vetted were either not followed or were ineffective. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● The provider had not improved use of the electronic call monitoring system following the last inspection.
● They had also failed to evidence why staff who posed a potential risk to vulnerable people were safe to employ.

Systems and processes to safeguard people from the risk of abuse
● People and their relatives told us they felt the service was safe.
● Staff were able to describe to us what action they would take if they suspected a person was at risk of abuse.
● Staff confirmed they had received training in safeguarding and were able to describe the different types of abuse that could occur. Staff, however, had failed to raise concerns for an individual who was regularly cancelling calls or refusing the care and support deemed necessary.
● A safeguarding policy and procedure was in place and provided information about how to escalate concerns.

Using medicines safely
● Staff received training to administer medicines and were competency checked before they supported people with medicines. Staff told us they felt confident to administer medicines.
● We saw audits of medication administration records (MAR's) were undertaken by office staff.
● Errors were communicated to care staff and action taken where warranted, for example additional training.
● Disciplinary action had been taken with some staff following medication errors.

Preventing and controlling infection
● Staff received training in infection, prevention control.
● Staff carried disposable gloves and aprons with them when delivering care. Staff told us they had good access to personal protective equipment, including alcohol hand gel, to help them manage infection control.
● The provider had shared government guidelines and other information about COVID-19 with staff.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as required improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed in the robust oversight and management of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

- Following the last inspection, the provider submitted an action plan which described the improvements that would be made to the service. At this inspection, the registered manager and provider were unable to demonstrate improvements made to the service in respect of consistent use of the electronic call monitoring system by staff and management and oversight of the service.
- The registered manager and nominated individual did not demonstrate clear knowledge of regulatory requirements.
- Systems to monitor the quality and safety of the service were either not in place or were ineffective as the provider had not identified the issues we highlighted during the inspection, such as those relating to recruitment, timely care planning, oversight of risk and use of the electronic call monitoring systems.
- We found there was insufficient oversight of the service, including the two satellite hubs in Wakefield and Congleton. The registered manager of the Manchester branch was unable to devote the time needed to the Manchester service as they also assumed a regional role within the wider iCare company
- An action identified from the last inspection was not being fully implemented as visit durations were not audited by management. Short call visits or those being regularly cancelled by people were not referred back to commissioners to check if people remained safe or if the call was required.
- During the on-site visit, records we requested in relation to the two satellite hubs, such as people's care plans and staff files, were not made available. The registered manager stated records had been taken to corresponding satellite hubs. We were not assured that people's personal details were being maintained securely.
- Where action had been taken to try and improve quality and safety of care this did not always accurately reflect the provider's policies or processes. We were not assured that disciplinary action taken with staff was effective as mistakes continued to be made.

The delivery of high-quality care was not assured by the leadership and management of the service. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The rating from the previous inspection was displayed in the office and on the company's website.
● The provider had made it possible for staff to access a training application from their mobile phones.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Electronic call records were not always completed or used accurately by staff. Where the office had completed call logs on behalf of staff these did not always reflect the time staff spent delivering personal care.
● Management did not ensure that detailed care plans were completed and in place prior to a package of care starting.
● Records we requested in relation to people's packages of care did not match those commissioned by the local authorities.
● Audits of the service had not identified these issues and so good outcomes for people were limited.

We found no evidence that people had been harmed however, this was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Working in partnership with others
● The service worked with a number of local authorities and clinical commissioning groups to assess and support people in the community.
● Feedback from local authorities we contacted was mainly negative. Professionals we spoke with told us of the delays experienced when requesting documentation, for example, in relation to safeguarding enquiries.
● At the time of this inspection two local authorities were not commissioning new packages with iCare Solutions Manchester Ltd.
● After this inspection another local authority also suspended placements. They were not assured that people were receiving a safe service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Some systems were in place to gather feedback from people regarding their views of the service they received.
● Feedback from people had been gathered via telephone reviews in the main due to the COVID-19 pandemic. It wasn't clear what action had been taken by the service to improve or meet people's preferences following feedback.
● There had been limited engagement with staff in relation to supervision and appraisals. The COVID-19 pandemic had meant that contact with staff was mainly by telephone and was irregular.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager was aware of their responsibilities in relation to the duty of candour.

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 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff received pre-employment checks prior to commencing employment, however, these were not always appropriately actioned or followed up. Actions identified to mitigate identified risks were not followed.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Usage of electronic call monitoring was inconsistent across all areas of the business. Records indicated some calls were cut short. People did not regularly receive their commissioned support in full therefore, person-centred was not being provided.

The enforcement action we took:

Warning notice - repeat breach of regulation 9

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to monitor the quality and safety of the service were either not in place or were ineffective. Provider oversight was limited, particularly the management and oversight of the two satellite hubs. Practices were inconsistent and there were gaps in the oversight of risk. Where action had been taken to try to improve the quality and safety of care this did not always accurately reflect the provider's policies or processes.

The enforcement action we took:

Warning notice - repeat breach of Regulation 17