Intercare Services Direct Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Intercare Services Direct Ltd is a domiciliary care service which provides personal care to adults with a range of support needs in their own homes. At the time of this inspection the service was supporting 142 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
At the time of inspection. the service was being managed by the provider's head of operations and they had applied to register with the CQC.

People and relatives spoken with did not share any concerns about people's safety. We received mixed views about the quality of care provided. Some people and relatives were satisfied with the quality of care provided and made positive comments about the care staff. However, some people and relatives raised concerns about the lack of continuity of care. The head of operations told us during the pandemic it had been even more difficult to ensure people received good continuity of care due to seriously low staff levels at time, often at short notice.

The assessment of people's individual potential risks and/or the measures in place to reduce and manage the risks to the person required improvement. The proper and safe management of medicines required improvement to ensure people received medicines at the right time and/or for best effect. Safeguarding procedures were robust and staff understood how to safeguard people. Care staff told us office staff responded to their calls for assistance promptly. A new accident and incident procedure had been introduced at the service and this was being embedded into service practice.

The provider had completed pre-employment checks for new staff, to check they were suitable to work at the service. Care staff told us the service had been short staffed during the pandemic. They told us they had been asked to complete additional calls as there were not enough staff to cover unexpected absence. The head of operations told us that care coordinators and managers have made every effort to keep rotas to as close to the originals as planned. However, last minute changes to rotas have been necessary to ensure service delivery was met during periods of being short staffed.

We found concerns about some people's care plans and risk assessments. For example, we found some people did not have risk assessments and/or care plans in place for specific health care conditions. Two of the care plans we looked at contained significant contradictions. Although we did not find this had negatively impacted on people using the service; there was increased risk people would not receive appropriate care and achieve good outcomes

Most staff felt supported. The system in place to ensure all staff received regular one to one sessions

required improvement. Staff received a range of training and support relevant to their role. Some staff told us they had not received some relevant specialist training or it had been of a poor quality. We shared this feedback with the head of operations.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The provider had systems in place to engage and involve people using the service and their representatives. However, relatives and people shared concerns about the poor response to their calls to the office. Staff did not always ring back as promised. This showed there were missed opportunities to continue to learn and improve service delivery.

Our findings during the inspection showed the systems in place to assess, monitor and mitigate the risks relating to the health and safety of people was not effective in practice.

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

Rating at last inspection
The last rating for this was Good (published 31 January 2020).

Why we inspected
The focussed inspection was prompted in part by notification of a specific incident. This incident was being investigated by the local safeguarding authority. This inspection did not examine the circumstances of the incident. The information CQC received indicated concerns about the safe care and treatment of people, particularly in relation to risk management. This inspection examined those risks. We undertook a focussed inspection to review the key questions, safe, effective and well-led only.

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

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We found evidence the provider needs to make improvement. Please see the safe, effective and well-led sections of the full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Intercare Services Direct Ltd on our website at www.cqc.org.uk.

Enforcement
We identified breaches in relation to the management of people's risks, records and quality assurance.

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.

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

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Intercare Services Direct Ltd

Detailed findings

Background to this inspection

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

The was a focussed inspection. The information received by the CQC indicated concerns about the management and safety of the service. This inspection examined those concerns.

Inspection team
The inspection was carried out by two inspectors and two Experts 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. Two inspectors provided additional support to complete telephone calls to care staff.

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 did not have a manager registered with the Care Quality Commission. The head of operations had applied to register with the Care Quality Commission. This means the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The inspection was announced. We gave a short period notice of the inspection because the location provides a domiciliary care service and we needed to be sure that someone would be available to support us with our inspection.

Inspection activity started on the 4 January 2021 and ended on 11 January 2021. We visited the office location on the 7 January 2011.

What we did before the inspection
We reviewed the information we held about the service, which included correspondence we had received and any notifications submitted to us by the service. Statutory notifications are information the registered provider is legally required to send us about significant events that happen within 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. We took this into account when we inspected the service and made the judgements in this report.

We contacted social care commissioners who help arrange and monitor the care of people using the Intercare Services Direct Ltd. We also contacted Healthwatch Sheffield. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We spoke with 11 people who used the service and 10 relatives about their experience of the care provided by telephone. We spoke with 16 members of staff including the head of operations, the service manager, the business support officer and 13 care staff.

The head of operations was responsible for supervising the management of the service on behalf of the provider. They sent us a range of records prior to our visit to their office location. This included records relating to the management of the service, including policies and procedures. This enabled us to review these records and reduce our time at the office location.

We reviewed a range of records. This included four people's care plans and risk assessments. We also reviewed the systems in place to manage people's medicines safely. We looked at three staff files in relation to recruitment and staff supervision.

After the inspection
We obtained clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Using medicines safely
• The assessment of people's individual potential risks and/or the measures in place to reduce and manage the risks to the person required improvement. For example, some people's moving and handling risk assessments did not include the information required by the provider's own policy and/or clear guidance for staff. Some people did not have risk assessments in place for specific health conditions.
• Two of the care plans we looked at contained significant contradictions. These included contradictions in significant areas such as choking, mobility and skin integrity. For example, one person's plan of care stated they did not have a choking or swallowing difficulties or dietary requirements. This contradicted another plan which stated they could choke and information on how to thicken their drinks.
• There were no records to show checks had been completed on the care equipment used by staff to support people in their homes. The provider was introducing new documentation to record these checks.
• Some people required time critical or time sensitive calls. For example, a person who was required to eat at a specific time for their medication or a person who was prescribed time sensitive medicines. We found the system in place to ensure people received their calls at the right time required improvement.
• Some people's care plans did not contain guidance to help staff decide when to administer medicines prescribed 'when required'. This meant there was a risk these medicines might not be used safely or to best effect. The guidance in place for the application of topical medication in some people's medication records also required improvement.
• During the inspection we were notified of an incident concerning the management of a person's controlled drugs (CD). This showed the safe management of CD's required improvement.

Although we did not find this had negatively impacted on people using the service; there was increased risk that people could be harmed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• A serious incident occurred at the service in November 2020. As part of their lessons learnt the provider reviewed their accident and incident policy and procedures. Staff were provided with additional guidance and training.
• At the time of the inspection the new policy and procedures were being embedded into practice. The provider sent us examples of the new procedures being used by staff.

Staffing and recruitment
• There were sufficient staff employed at the service. However, the head of operations told us it had been

difficult to ensure people received their calls on time and be supported by regular care workers during the pandemic. There had been a significant increase in staff unexpected absence, often at short notice due to COVID-19. The head of operations told us that care coordinators and managers had made every effort to keep rotas to as close to the originals as planned. However, last minute changes to rotas had been necessary to ensure service delivery was met during periods of being short staffed. The provider was actively recruiting additional care staff for the service.
• This inconsistency of staffing levels due to the pandemic was reflected in the feedback received from people and relatives. Comments included, "I have raised the late tea time visits and they say they are short staffed" and "My times have been horrendous, I have a call at 7 o'clock in a morning, but a couple of days a week the carer can't get to me until 9.30 to 10 am."
• The challenge of maintaining staffing levels during the pandemic was also reflected in the feedback received from staff. Care staff told us the service had been short staffed. Staff had been asked to fit additional calls into their rota. One staff member said, "Because they are short staffed, they [care coordinator] cram your rota so you have too many clients to get to. The other day I was out from 6:15am to 12noon just doing the morning run." Staff also told us the five minute travelling time provided did not always reflect the actual time it took to travel to their next visit.
• The provider had completed pre-employment checks for new staff, to check they were suitable to work at the service.

Preventing and controlling infection
• Staff had access to personal protective equipment (PPE) such as gloves, masks and aprons. The head of operations told us the provider had taken multiple steps to ensure PPE was correctly worn by staff. For example, staff emails, bulletins and webinars. All staff had completed infection control training.
• Most people and relatives told us staff used gloves, masks and aprons appropriately whilst supporting them or their family member. We were informed about some isolated incidents of staff not always wearing their mask in people's homes or an apron whilst providing personal care. We shared this feedback with the head of operations, they told us they would take immediate action about these concerns.

Systems and processes to safeguard people from the risk of abuse
• People did not express any concerns about their safety. Some people described how the delivery of inconsistent and late calls caused anxiety.
• Systems were in place to safeguard people from abuse. We reviewed the service's safeguarding file; the nature of each allegation, the outcome and the action taken was clearly recorded.
• Staff had undertaken safeguarding training. Staff were knowledgeable about their role and responsibilities in keeping people safe from harm. Staff told us they would always report any concerns to the senior staff.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet

• The assessment of people need's and choices considered aspects of their needs and the information was used to develop written care plans and risk assessments. Protected characteristics under the Equality Act were considered. We found that some people's care plans did not fully consider their specific health or medical conditions. For example, one person did not have a catheter care plan in place.

•Two out of the four care plans we reviewed contained significant contradictions. It is important that each person using a service has an accurate, complete and contemporaneous care plan in place

Although we did not find this had negatively impacted on people using the service; there was increased risk people would not receive appropriate care and achieve good outcomes. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People told us they had been actively involved in the planning of their care. Relatives told us they were fully involved in their family member's care planning.

• We received mixed views from people and relative about the quality of care. Some people and relatives were satisfied with quality of care and made positive comments about the staff. One person said, "Nothing, but praise for the carers." Whilst some people and relatives were less satisfied.

• People told us they were asked their meal and drink choices by staff. Relatives told us their family member was supported appropriately with meals. Comments included, "They [Care staff} prepare his [family member food; breakfast , a sandwich and microwave food, they do look after him" and "Sometimes they fetch her [family member] fish and chips as a treat."

Staff support: induction, training, skills and experience

• Staff were supported to undertake the Care Certificate. The Care Certificate is an identified set of standards health and care professionals adhere to in their working life.

• Staff received a range of training to support them in their role. Some staff told us they had not received any catheter or PEG training or the training provided had been of a poor quality. We shared this feedback with the head of operations so appropriate action could be taken to provide training.

• Most staff told us they had received regular one-to-ones and appraisals. However, some staff told us they had not received regular sessions. The feedback was reflected in the staff files we looked at. This showed the system in place to ensure all staff received regular supervision required improvement.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support:
• The service had processes for referring people to other services, where needed.
• People told us care staff contacted community health professionals when they were feeling unwell.
• In people's records we found evidence staff sought advice from community health professionals such as the GP and district nurse. This process supported staff to achieve good outcomes for people and to help people maintain their health.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA

• The service was working within good practice guidelines.
• At the time of the inspection none of the people supported by the service had a Court of Protection Order in place.
• Care staff had received training in the MCA. People told us care workers consulted them and asked for their consent before providing care and support.

Requires Improvement

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

• At the time of inspection. the service was being managed by the provider's head of operations and they had applied to register with the CQC. The provider had recently introduced new incident and accident policy and procedures. These were being embedded into service practice.
• During the inspection we found concerns relating to the quality of people's risk assessments and care plans. This showed the system in place to assess, monitor and mitigate the risks relating to the health and safety of people using the service required improvement. It also showed the auditing of people's risk assessments and care plans was ineffective in practice.
• There were incidents where care staff had not been able to access people's electronic medication administration records (MAR) due to Wi-Fi problems. Staff were unable to sign confirmation they had administered their medication so office staff had signed the person's MAR. We found there were no contingency plans in place.
• The provider had systems in place to engage and involve people using the service and their representatives. For example, the provider sent out a questionnaire and office staff contacted people to obtain their views about their experiences of care. However, relatives and people shared concerns about the response to their calls to the office. Comments included, "When I ring to complain, they say they will ring you back, but they [office staff] never do" and "When you ring and talk to a person, they [office staff] say they will ring back and they never do." This showed there were missed opportunities to continue to learn and improve service delivery.

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

• People and relatives also raised concerns about the service's out of hours telephone service. "I phoned the mobile number for the office as it was after 4,00pm. There was no reply, I tried several times then left a message, but still never heard from them" and "It's an answering machine, if you leave a message, they [office staff] never get back to you." The head of operations told us the provider had identified an issue with their phone lines and the call divert facility. The provider had worked with their telephone provider to

resolve the issue and this was being monitored.
• We received mixed views about the quality of care from people and relatives. Positive comments included, "Nothing but praise for the carers," "They [staff] really do their best" and "Dignity is at the forefront, she [staff] puts the light on once the curtains are drawn. I feel sound when she comes in a morning." The provider had written to people at the beginning of pandemic. People were informed there may temporary disruption to their service due to staffing levels. This meant they may be attended by care workers they did not know or their calls times were adjusted. If the service was without adequate care workers, the provider would begin to look at prioritising those people most at need. The provider was actively monitoring the staffing levels at the service and obtaining assistance from the local authority when needed to ensure people received their calls.

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 head of operations was aware of their obligations for submitting notifications in line with the Health and Social Care Act 2008.
• The head of operations shared information on how the provider had learned from mistakes and admitted when things went wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

Working in partnership with others
• The service worked with other agencies such as the local authority and clinical commissioning groups who commissioned care for some people living in the home.
•The service and provider were also working in partnership with Age UK, the Primary Care Trust and York University on different pilots and/or projects.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The assessment of people's individual potential risk and/or the measures in place to reduce and manage the risk to the person required improvement. The provider had not done all that was reasonably practicable to mitigate any such risks including those relating to medicines.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance We could not be assured the provider had effective systems or process in place to assess, monitor and improve the quality and safety of the service provided. The provider had not ensured each person using the service has an accurate, complete and contemporaneous care plan in place.