Kwikfix Recruitment Services Limited

Oxford Branch

Inspection report

Kwikfix Recruitment Services Ltd
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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Kwikfix Recruitment Services Limited Oxford Branch is a domiciliary care service providing care to people in their own homes. The service provides support for adults over and under the age of 65, people with dementia, learning disabilities and physical disabilities.

People's experience of using this service and what we found
This was a targeted inspection that followed up the warning notice served at the previous inspection around the safety of the service.

We use targeted inspections to follow up on Warning Notices or to check concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

The provider had made some improvements in relation to risk assessment, staff knowledge and training and guidance.. However, we found improvements were still required in relation to safe medicines management and learning from incidents and accidents.

Systems to ensure the safe managements of medicines were still not fully effective in ensuring good standards of care were delivered. People's medicines support needs had not been adequately reviewed or updated since the last inspection.

People's care plans had not been reviewed in order to asses people's risks and needs and document the support people required. Some of the checks and changes identified as being complete within the service's action plan had yet to be updated or implemented.

Since the last inspection, the service had ensured; staff competencies were updated, further training was completed, and spot checks were carried out in order to ensure safe practice. Documentation had also been provided to staff to ensure they understood one person's support needs, and the risk associated with this.

Staff had a good understanding of people's needs and the support they required.

Following the last inspection the provider sent an action plan detailing how they would meet the warning notice. Not all of these actions had been completed at this inspection, which indicated further concerns about the effectiveness of the provider's quality assurance and governance systems. During the last inspection, we found the provider was in breach regulation 17, good governance, this was documented within the previous report.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the

overall rating.

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 21 October 2022).

At the last inspection we served a warning notice around safe care and treatment. At this inspection we found that some improvements had been made. Therefore, the provider had partially met the warning notice, however remained in breach of regulations.

The provider remained in breach of regulations around safe care and treatment as further improvements were required and needed embedding into practice. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Why we inspected
We undertook this targeted inspection to check whether the warning notice we previously served in relation to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. The overall rating for the service has not changed following this targeted inspection and remains requires improvement.

Enforcement and Recommendations
The provider remains in breach of regulations found at the last inspection. These relate to keeping people safe from potential abuse, assessing risks and needs and mitigating risks to people.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

We will request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

You can read the report from our last comprehensive inspection, on our website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

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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 Health and Social Care Act 2008.

This was a targeted inspection to check whether the provider had met the requirements of the Warning Notice in relation to Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a concern we had about the safety of the service.

Inspection team
The inspection was carried out by one inspector.

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

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from partner agencies and professionals. On-going monitoring such as information received. We used all this information to plan our inspection.

During the inspection
We spoke with the operations manager and the registered manager. We also sought the views of staff who worked at the service. We reviewed care plans and a range of records related to the management of the service including policies and procedures, audits and risk assessments.
After the inspection
Following the inspection we had a discussion with the local authority's quality team who plan to work with the service, to support them with their ongoing improvement.

Inspected but not rated

Is the service safe?

Our findings

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

At our last inspection this key question was rated requires improvement. We have not changed the rating as we have not looked at all of the safe key question at this inspection.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served. We will assess the whole key question at the next comprehensive inspection of the service.

At our last inspection systems were not established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service placing them at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We served a warning notice and told the provider to meet Regulation 12 within three months of the last inspection. We went back to check that the warning notice had been met. Although improvements had been made, the provider remains in breach of Regulation 12.

Following the last inspection, the registered manager sent us a detailed action plan which demonstrated the actions they had taken and planned to take in order to ensure that people using the service were safe.

Assessing risk, safety monitoring and management

- We saw that changes made to the use of the care planning system was in use. We saw examples of this new way of working had been implemented and that new clients had the relevant documentation in place in order to make it easier for staff to access people's care plans, risk assessments and relevant details.
- Since the last inspection, the provider had taken action to ensure that staff were competent and had the skills and experience to provide care and treatment to service users. This included retraining staff, spot checks, competency assessments, and team meeting discussions around safeguarding individuals.
- At the last inspection we found there were limited risk assessments and additional information available in place for people who had specific health care conditions. This meant people were at risk of avoidable harm. At this inspection we found that some improvements had been made in respect to people's risk assessments in order to guide staff to provide appropriate support. We saw appropriate training had been completed. Risk assessments and further information relating to diabetes had also been implemented.
- At the last inspection, we saw that there was limited documentation to investigate incidents this posed a potential risk of harm to the service user. There was now a tracking document in place which logged incidents, accidents and safeguarding concerns. We reviewed individual accidents and incidents and did not always see appropriate actions or outcomes documented. Therefore, it was not clear what action the service had taken to mitigate risks or investigate concerns, trends or themes. We were not assured that improvement had been made to prevent further occurrences of incidents or that appropriate action was taken.

The warning notice has been partially met, although we found no evidence that people had been harmed, systems and processes were still not fully established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Using medicines safely

● At the last inspection we found that time specific medicines were not documented in one person's documentation. This put this person at risk of potential overdose. At this inspection, we found that although the care plan had been updated to reflect that they took time specific medicines, it did not identify what medicine this was, or the risk associated with this. The provider told us that they had audited this person's medicines for reassurance of safe administration, however, due to the nature of the call times and limited knowledge of when they last took this medicine, this was not effective. The service had not ensured that information around how to support people to safety manage their medicines was safe. Staff we spoke with were able to identify the need for time gaps, however, were not assured that the timings of their visit supported safe medicine administration.

● At the last inspection, we found that people's support needs were not correctly identified within their care plan. For one person, their initial assessment identified they required support to administer their medicines, within their can plan it stated that staff were to prompt them to take medicine. The action plan from the service identified that this was reviewed and updated to reflect administration, and a staff meeting held to discuss this. We saw that there was no documentation in place to ensure that correct assessments or reviews had been carried out, and team meetings reflected limited information about medicine management. Staff we spoke with confirmed that they were supporting to this person to administer their medicines as it was unsafe to only prompt as this person was unable to see.

The warning notice has been partially met, although we found no evidence that people had been harmed, systems and processes were still not fully established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014