ICare Solutions Wirral Ltd

Icare Solutions (Wirral) Ltd

Inspection report

31 Liscard Village
Wallasey
CH45 4JG

Tel: 01512715227

Date of inspection visit:
17 June 2021
18 June 2021

Date of publication:
26 July 2021

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 (Wirral) Ltd is a domiciliary care agency providing personal care to people in their own homes. 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. At the time of the inspection, 78 people were receiving support with personal care.

People's experience of using this service and what we found
Risk to people was not always assessed and managed appropriately. As a result, staff did not have access to accurate and up to date information regarding people's support needs to maintain their safety. Risk assessments were not always accurate and when risks had been identified, actions had not been taken to minimise the risks. Care plans were not always updated to reflect changes in people's needs.

Medicines were not managed safely and people did not always receive their medicines when they needed them. Records of administration were not completed accurately or robustly; call times did not always allow for sufficient time between doses of medicines and medicines were not always administered as prescribed. Not all staff had had their competency to administer medicines safely assessed.

People did not always receive support at the scheduled times, by staff that knew their needs, or for the length of time the call was planned for. This had a negative impact on the quality of care people received. Not all safe recruitment checks were completed to ensure staff were suitable for the role.

Infection, prevention and control measures were not always followed to minimise risks both within the office and in people's homes. People told us care staff did not always wear masks and there was no evidence of staff being tested for COVID-19.

Systems were in place to monitor the quality and safety of the service, but they were ineffective. They did not identify all areas of the service that required improvement, were not always accurate and when actions were identified, the actions were not always completed.

People and their relatives did not always feel the service was well managed. They described lack of consistency, staff that did not know their needs and late or missed calls. However, people who received care from regular carers were more satisfied with the support they received.

Staff were aware how and when to report any safeguarding concerns they had and there was a policy in place to guide them. Records showed appropriate actions had been taken following accidents and incidents to reduce risk to people. Family members were informed when this happened.

CQC had been informed of incidents providers are required to inform us about. There were some systems in

place to gather people's feedback about the service, including staff meetings and quality assurance surveys.

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 inadequate (published 15 January 2021) and there were breaches of regulations identified in relation to risk management, staffing and the governance of the service. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection enough improvement had not been made and the provider was still in breach of regulations. Please see the safe and well-led sections of this full report.

We inspected the key questions of safe 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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for ICare Solutions (Wirral) Ltd on our website at www.cqc.org.uk.

Why we inspected
This was a planned inspection based on the previous rating.

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 safe care and treatment, staffing, recruitment and the governance of the service at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is still 'Inadequate' and the service remains 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 (Wirral) 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.

Inspection team
The inspection was undertaken by two inspectors 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
We gave a short period notice of the inspection because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 17 June 2021 and ended on 30 June 2021. We visited the office location on 17 June 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection and we sought feedback from the local authority.

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 used all of this information to plan our inspection.

During the inspection
We received feedback from five people receiving support and 13 relatives about their experience of the care provided. We also spoke with nine members of staff, including the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included seven people's care records and medication records. We looked at five files in relation to staff recruitment. A variety of records relating to the management of the service were also reviewed, including accidents, training, safeguarding information and audits.

After the inspection
We continued to seek clarification from the provider to validate evidence found and reviewed additional records provided after the site 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 inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At the last inspection, the provider was found to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks to people were not always safely assessed and mitigated to maintain people's safety. At this inspection, we found that enough improvements had not been made and the provider was still in breach of Regulation.

- Risks to people were not always robustly assessed or mitigated.
- Risk assessments were in place; however, they were not all effective. For instance, one person's moving and handling assessment had risks recorded within it, but no risk was identified on the form. Another person's risk assessment highlighted risks in relation to their mobility and skin integrity, but there were no measures in place to reduce those risks.
- Care plans viewed did not always provide clear and accurate information regarding people's needs and how staff should safely support them. These were not all updated when people's needs changed. A relative told us, "Following [change in needs] I expected the care plan to be updated but it hasn't been and I am worried now that [staff] aren't well trained enough to manage any [risks], it's very poor."
- Some people received care from staff that knew them and felt safe. However, other people continued to receive support from inconsistent staff who did not always know their needs. One person told us, "When [new carers] come, they come blind; no clue what I need so I don't feel so good about them." Relatives said, "Many times a stranger comes, someone [name] has never met before and there is no handover, no induction to the person they are coming to care for" and "I have no issues with the regular carers but lots with other random people."

Failure to assess and manage risks robustly is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At the last inspection, the provider was found to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because medicines were not always managed safely. At this inspection, we found that sufficient improvements had not been made and the provider was still in breach of Regulation.

- There were medication administration records (MARs) in place, but they were not always completed accurately. There were multiple gaps in the recording of administration of medicines, allergies were not

always recorded and doses for one medication prescribed 'as required', was not recorded. Correct codes were not always used to indicate when and why medications were not administered. The provider told us a new electronic medicine management system will soon be introduced, which they hope will lead to improvements.

● Records showed that people did not always receive their medicines safely as enough time was not allowed between calls. A relative told us, "The intervals between the medicines are wrong because of their poor time keeping and I don't think that they understand the importance of the timing and gaps between medicines." Other records showed medicines were left out for people to take at later times. One person's records showed they did not always take the medicines that had been left out for them.

● A relative told us a carer had chosen not to give their relative pain medication and told them, "I didn't bother giving it to her as she takes so many." They checked the MAR and found this had happened several times. The person was in pain and has since been admitted to hospital.

● Not all staff had had their competency assessed to ensure they could administer medicines safely.

Failure to ensure the safe management of medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing

At the last inspection, the provider was found to be in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was not always enough staff to attend people's scheduled calls at the planned times, or for the full duration. At this inspection, we found that sufficient improvements had not been made and the provider was still in breach of Regulation.

● There was not always enough staff to ensure calls were undertaken at the planned times, or for the full duration. Records reviewed showed that people received multiple calls more than thirty minutes later than the planned time and many lasted less than half of the planned duration.

● Although some people had established call times and regular carers, others did not. People told us, "[Name] gets very anxious as she never knows who is coming", "Weekends, school holidays, bank holidays are all predictably bad as so low in staff; it's a big issue", "It's all a rush and definitely not safe", "Weekends are the nightmare as they often come from out of town, don't know you and have lots of people to see", "They have missed calls a couple of times and then one came in the afternoon when it should have been the morning."

● Staff rotas showed most calls were planned appropriately. However, some rotas showed they had more than one call scheduled at the same time and others had little or no travel time incorporated into this to enable them to travel between people's homes and still arrive on time.

● One relative told us their family members evening call had recently been missed completely. This meant they did not receive prescribed pain relief and was left in pain. Another person told us a staff member arrived at 1.45pm to make their breakfast.

Failure to ensure enough staff are available to meet people's needs in a timely way is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment

● Not all safe recruitment checks were completed to ensure staff were suitable for the role.

● Records showed recently recruited staff had undertaken a Disclosure Barring Service check. However, appropriate professional references were not always sought, or verbal references verified.

Failure to ensure robust safe recruitment procedures are followed is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● Infection, prevention and control measures were not always followed to minimise risks.

● We saw that not all staff wore masks in the office and people told us care staff did not always follow current guidance regarding the use of personal protective equipment. People told us, "They are good at wearing gloves, but they don't all like the masks and I don't say anything" and "They don't wear aprons and not always masks which concerns me."

● There was no evidence of staff COVID-19 testing recorded. Some staff told us they completed tests, but others did not. Since the inspection the registered manager told us all staff are required to complete and record a test each week.

● Not all staff had completed infection control training since the COVID-19 pandemic began.

Failure to ensure infection prevention and control measures are adhered to in order to maximise people's safety is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● Procedures were in place to ensure safeguarding concerns were reported and recorded appropriately.

● Staff had undertaken safeguarding training and were clear about their responsibilities in reporting and recording any concerns. A policy was also in place to guide them.

Learning lessons when things go wrong

● Accidents and incidents were recorded and reviewed.

● Records showed appropriate actions had been taken following incidents to reduce risk to people. For instance, there were a high number of incidents regarding skin integrity, so training was arranged for staff to raise awareness.

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 inadequate. At this inspection this key question has remained the same. 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.

Continuous learning and improving care

At the last inspection, the provider was found to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because systems in place to monitor the quality and safety of the service were not effective. At this inspection, we found that enough improvements had not been made and the provider was still in breach of Regulation.

- New governance systems had been implemented since the last inspection, to monitor the quality and safety of the service, but they were not effective.
- Audits did not identify all areas that required improvement, such as those we highlighted at this inspection.
- Records showed that audits completed were inaccurate and contradictory.
- When actions were identified from audits, they were not always completed. For example, the action recorded on a MAR chart audit stated a staff member was to complete a medicine competency assessment within two weeks, but this had not been completed.

Failure to ensure effective systems are in place to monitor the quality and safety of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider told us they would begin completing all the audits themselves until staff were fully competent to complete robust audits.
- The provider and registered manager were working through an action plan to help improve the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The culture of the service did not always help to ensure good outcomes for people.
- People and their relatives did not always feel the service was well managed. Comments included, "I think that they have good intentions, but they can't deliver a safe service with the staff that they have" and "I no longer bother complaining as I only get empty promises."
- However, those people who received care from regular carers were more satisfied with the support they received. They told us, "I feel confident in them and asked for them again when [name] came out of hospital."
- It was the same for staff; those with continuity enjoyed their jobs and felt supported, whilst those without

continuity did not. They told us, "I get messed around every week and moved runs all the time. Constantly allocated to different people, don't think the office staff have a clue, no idea what they are doing" and "ICare is a good service but the office isn't organised. I get moved runs all the time, so don't really get to know people. "

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 and provider were aware of their responsibilities in this area and a policy was in place to support this.
- Records showed that people's family members were informed if any incidents occurred.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The Commission had been informed of reportable incidents and events providers are required to inform us about.
- A range of policies and procedures were in place to help guide staff in their roles.
- The provider told us they were aware of best practice guidance, such as that regarding medicines management.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Staff meetings were held to enable staff to share their views regarding the service and receive any updates.
- The provider was working with the local authority's quality team to help make improvements to the service.
- Some systems were in place to gather feedback from people who used the service and their relatives. Records showed actions had been taken to address any issues raised.