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

Date of inspection visit:
05 September 2018
06 September 2018
07 September 2018

Date of publication:
30 November 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 5, 6 and 7 September 2018 with the inspection being announced as we needed to give the provider notice. The inspection was carried out by one adult social care inspector and an expert by experience. On 6 September 2018 we made calls to people who use the service and staff to gain their views and experiences of the service.

ICare Solutions – Manchester is a domiciliary care service which provides personal care and support to people in their own homes to help them remain independent. They provide other elements of support such as sit-in services, domestic support and welfare checks. The service is managed from an office in Trafford, Greater Manchester with care and support provided for people living in the immediate area and other districts within Greater Manchester, including Stockport, Salford and Irlam. The length of visits for care and support vary depending on the assessed needs of people. At the time of this inspection 321 people were in receipt of a service and the company employed 201 community staff and 11 office staff. However, not everyone using the service receives regulated activity; the Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

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

This was the first inspection of this service at this location. Our last inspection of this service had been at a previous address and was carried out in December 2016, where we rated the service overall as Requires Improvement. At the last inspection we identified breaches of Regulation 11 and Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff did not understand or receive training in the Mental Capacity Act 2005 and the governance of the service required improvement.

The agency had moved to larger premises in August 2017 and had grown the business in size, providing care and support in the four areas of Greater Manchester. The areas of Salford and Stockport were kept separate from the main business of Manchester and Trafford, with each having an assigned care manager or co-ordinator to oversee the day to day basis, with oversight of all from the registered manager.

Recruitment processes were not always safe. Appropriate checks on staff had been undertaken however these checks had not always been carried out before staff began working for the service. Risk assessments completed when Data and Barring (DBS) checks identified staff with any previous convictions were not fit for purpose. Staff using the electronic call monitoring system correctly provided evidence that personal care calls had actually occurred but this was not being used by all staff. Medicines were sometimes stored in a locked tin and accessed only by care staff, therefore people were kept safe from the harmful effects of too

many medicines. Staff received training on how to recognise abuse and understood what action was required if they should encounter it.

The registered manager used the interview process to ensure staff had the right skills, knowledge and experience to do the role. Training records showed staff had undertaken training in the Mental Capacity Act 2005 (MCA) and the service understood their responsibilities in how to implement this should someone not have capacity. Care plans reflected contact with health and social care professionals involved in people's care if any health or support needs changed. People received healthcare support, sometimes as a result of intervention or advice from care staff.

Not all staff were caring and professional in their practice as we saw false recordings in a person's communication log book. We brought this to the registered manager's attention so that they could take appropriate action. The service promoted equality and diversity. Company policies and procedures covered the protected characteristics under the Equality Act. Staff were aware of the importance of maintaining and building people's independence as part of their role.

Support plans were person centred and people confirmed they had been involved in developing these at the start of their care and during any reviews since. There was a good mix of male and female care workers employed and the service could offer clients a choice with regards to the gender of the care worker. The service also tried to allocate staff with shared interests or something in common with the person they were supporting. Staff we spoke with were aware of the complaints policy and informed the office or a line manager if people wanted to make a formal complaint.

There were examples of good practice going on in some areas but these were not replicated across all areas of the business. There was a lack of consistency and the registered manager did not have oversight of all aspects of the business. Each area tended to operate as a stand-a-lone service. Field observation spot checks were carried out to check on staff practice and test staff knowledge about the care and support they provided for individuals. The service linked in with other agencies and worked in partnership with them. Audits of the service had not identified the issues we found with unsafe recruitment practices and false recordings.

At this inspection we identified a new breach in Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to unsafe recruitment practices and a repeated breach of Regulation 17. You can see what action we told the provider to take at the back of the full version of the report.

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

Recruitment practices were not always safe. Risk assessments completed in respect of any staff with previous convictions were not fit for purpose.

Medicines were sometimes stored in a locked tin and accessed only by care staff so people were kept free from harm.

Staff received training on how to recognise abuse and were aware of how to raise a safeguarding alert.

Is the service effective?

Good

The service was effective

The interview process helped to ensure staff had the right skills, knowledge and experience to do the role.

The service understood their responsibilities in how to implement the Mental Capacity Act 2005 should someone not have capacity.

People received healthcare support, sometimes as a result of intervention or advice from care staff.

Is the service caring?

Requires Improvement

The service was not always caring.

Not all staff were caring and professional in their practice as we saw false recordings in a person's communication log book.

Training records we looked at showed that staff had undertaken training in equality and diversity.

Staff were aware of the importance of maintaining and building people's independence as part of their role.

Is the service responsive?

Good

The service was responsive.

Support plans were person centred and people had been involved in developing these at the start of their care.

The service could offer clients a choice with regards to the gender of the care worker as per their preferences.

Staff we spoke with were aware of the complaints policy and informed the office or a line manager if people wanted to make a formal complaint.

Is the service well-led?

Requires Improvement

The service was not always well led

There were examples of good practice in some areas but these were not replicated across all areas of the business.

Observation spot checks were carried out in people's homes to check on staff practice and test staff knowledge.

The service worked in partnership with other agencies, alerting other professionals when concerned for people's welfare.

iCare Solutions Manchester 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.

We gave the service 36 hours' notice of the inspection visit as the registered manager has remit for another location. We needed to be sure that they would be in. Inspection site visit activity started on 5 September and ended on 7 September 2018. We visited the office location on 5 and 6 September 2018 to see the registered manager and office staff; and to review care records and policies and procedures. An expert by experience contacted people using the service by telephone to gain their views on the quality of care provided. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On 7 September one adult social care inspector visited four people in their own homes and contacted staff working at ICare Solutions – Manchester Limited by telephone as part of our inspection of this service.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We contacted local authority contracts and commissioning teams to gather their views of the service. One local authority had recently lifted a temporary suspension and was commissioning with the service again.

During our inspection we spoke with the registered manager, the nominated individual, two care managers,

two care coordinators, an external training consultant, and five care workers. At the time of our visit the service was providing personal care and support to 321 people. There were 212 members of staff employed at the time of our inspection, which included 11 members of office staff.

We spent the first and second day of the inspection at the provider's registered office, speaking with staff and looking at records. These included six care plans and associated documentation, seven staff recruitment files, staff training records, supervision records, various policies and procedures and other documents relating to the management of the service.

On the third day of inspection we visited four people in their own homes and spoke with them to gather their views on the service. These visits included meeting, speaking with and observing staff who were there to provide support for the person. We looked at paperwork kept on file in people's homes relating to their care after asking for the individual's permission.

Requires Improvement

Is the service safe?

Our findings

People we spoke with and visited as part of this inspection told us they felt safe using the service. They told us they felt safe with care staff and free from bullying or abuse. We found however that not all practices at the service promoted people's safety.

We looked at how the service recruited staff and found these processes were not safe. Appropriate checks on staff had been undertaken, for example Disclosure and Barring Service (DBS) checks were carried out and references obtained, including one from the staff member's previous employer where possible. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also helps prevent unsuitable people from working with children and vulnerable adults. However, we saw on at least one occasion these checks had not always been carried out before staff began working for the service. We also saw examples of when DBS checks had not come back clear and whilst company risk assessments were on file, these were incomplete and therefore not fit for purpose. There were no explanations documented as to why the service deemed there were no risks in employing the individuals or what control measures were in place.

We looked at five staff files and saw that the newest staff files included basic numeracy and literacy tests that had been completed at interview stage. Candidates had to demonstrate a basic understanding of both numeracy and literacy at the interview stage. We saw one staff file had the completed paperwork on file, with all questions correctly answered however we questioned the validity of the test as we were not assured that this had been completed by the employee.

We found the service to be in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because recruitment processes were not always safe.

There was interview paperwork in place to record candidates' responses and the questions were relevant to the role of care worker. This meant that the provider ensured that staff providing care or treatment to people using services had the skills and experience to do so. Proof of identity was obtained from each member of staff, including copies of passports and evidence of the right to work in the UK where necessary.

The registered manager explained that an electronic call monitoring system was in place. Staff were able to use the telephone in people's houses free of charge to log in to indicate arrival and log out when leaving a property. This, when used, then supported evidence to the provider and commissioners of services that people were receiving correct levels of care as identified within care plans. The call monitoring facility was not being used by all staff however, for a number of reasons. Some people receiving a service did not have access to a landline telephone. Others had not provided permission for care staff to use their telephones. Only one local authority made it a contractual requirement for staff to use the electronic call logging facility therefore only staff providing care in that area used it on a regular basis. The provider had made attempts to encourage staff to use the electronic call logging facility with the introduction of incentive payments but these had not worked.

We looked at a number of call logs and from the records we viewed we saw that people were receiving the allocated amount of time for the majority of visits. This meant that people were protected from the risk of harm as care workers were staying for the duration of the commissioned call. Those staff using the electronic call monitoring system were using it correctly and these could be relied upon to evidence that personal care calls had actually occurred.

For those visits where staff had not logged in remotely, or were not able to do this, we discussed with the registered manager the possibility of missed calls. They told us about the real time alerts on the system that were monitored on a rota basis by staff in the office to prevent missed calls. We spent time with a manager but saw that real time alerts were not specifically followed up as there were too many of them. The service was reliant on being notified of missed calls by someone else, for example a customer, a relative, a member of staff or another professional. A missed call log was in place and we saw that four calls had been missed in August 2018 and five calls in July 2018. The log indicated the action the service had taken in responding to missed calls, for example reporting to safeguarding or sending a complaint response. At the time of this inspection the company was looking to improve in this area and move to a new monitoring method using mobile phones with a scanning application that staff would use on their arrival and before leaving a call. The provider indicated that all staff would be expected to use the digital application and this would alert office staff in a timely manner of any missed visits so that action could be taken to send an alternative care worker. We will check that the service has improved in this respect on our next inspection.

At this inspection we looked to see what considerations had been made for assessing risks. We saw that people's personal safety had been assessed and any risks identified had corresponding plans in place to minimise and mitigate these risks. Risk assessments included information for staff about the risk and any measures they should take to minimise the chance of harm occurring to an individual. Care plans we looked at in the office contained information in relation to risks that had been identified for individuals, for example in relation to their mobility, nutrition, the administration of medicines and in the event of a fire. Staff we spoke with told us how they checked equipment, for example wheelchairs, hoists and bed rails and the environment for any trip hazards and then followed the care plan or looked at other ways they could minimise any risks.

The registered manager told us there were enough staff employed to meet people's needs, and we found few instances of people failing to receive a planned care visit. Care workers had a thirty minute window from a scheduled call time in which to arrive and some people we spoke to were aware of this and understood staff were sometimes late due to circumstances outside their control, for example an emergency or traffic congestion. Call records we looked at reflected that staff carried out visits to people at times similar to those originally planned.

We checked the medicine administration records (MAR) for the people we visited and found the arrangements in place were safe. People we spoke with who had their medicines managed by care staff said it was done well. We saw that medicines were sometimes stored in a locked tin when deemed necessary and accessed only by care staff. This meant that people could not take these by mistake and were kept safe from the harmful effects of too many medicines.

Some people who used the service lived alone and staff required the use of a key to access their house. Keys were appropriately stored in a 'key safe' outside houses and people we spoke with receiving a service were satisfied with the way this was managed.

Staff received training on how to recognise abuse and possible harm to people using the service. They understood what abuse was and the action required if they should encounter it. Staff were also aware of

how to raise a safeguarding alert and when this should happen and told us they would be confident in doing this.

Staff received training and guidance on safe hygiene and infection control procedures during their induction and at regular intervals when undertaking refresher training. Staff were provided with protective equipment such as disposable gloves and aprons and people we spoke with as part of the inspection confirmed these were used by staff.

Good

Is the service effective?

Our findings

People and their relatives considered the service to be effective. Most people we spoke with considered staff were properly trained and told us that new, inexperienced staff were accompanied and supervised by more experienced, mature staff.

The registered manager used the interview process to ensure staff had the right skills, knowledge and experience to do the role. All the staff we spoke with and records we looked at, confirmed they had an induction when commencing employment. Staff employed without previous experience of working in the health and social care sector were expected to complete the Care Certificate, which is good practice. The Care Certificate is an identified set of best practice standards that health and social care workers adhere to in their daily working life. We were satisfied that staff completed the required elements of mandatory training and we saw examples of other relevant training courses completed by staff so that they could safely support people with specific health conditions or behaviours.

Staff received supervisions either face to face or over the telephone due to the nature of the business. Records we looked at showed staff had supervision sessions and these were documented. Staff we spoke with found the supervisions with their line manager beneficial as they could raise concerns about people they supported and discuss their own personal development.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA and if any applications had been made to the court of protection.

Training records we looked at showed staff had undertaken training in MCA and DoLS. The provider had policies and procedures on the Mental Capacity Act 2005 (MCA). The registered manager, the provider and care staff had an understanding of the MCA and their responsibilities and understood how to implement this should someone not have capacity and the need to support best interest decisions. This included those decisions that would require a discussion with family, and possibly other significant people, for example health and social care professionals.

We asked a social care professional for feedback about the service and they told us staff had a clear understanding of the needs of older people, especially those with a diagnosis of dementia. They deemed staff had "gone the extra mile" with some people being supported. However, this feedback was from a local authority professional from one particular geographical area and differed from that gained from another professional from a different local authority.

We saw that documentation on care files reflected that consent had been gained when appropriate to do so and from the right people, for example to consent to care and to receive medicines. This was either the customer or from a relative or representative with the relevant legal documentation, for example a Lasting Power of Attorney (LPA). Care plans in place were signed by the person where they had the capacity to consent to their care arrangements.
We judged that the service had improved with the regard to implementing the principles of the MCA 2005, staff were better trained and the service was compliant in this aspect. However, feedback we gained highlighted a lack of consistency in the support provided across the company as different areas tended to operate as stand-a-lone services and the registered manager assured us this would be dealt with via additional training and supervision sessions.
People were supported with the preparation of meals and drinks where this had been identified as a care and support need during the assessment process. The exact level of support a person needed was recorded in the care plan along with any specific dietary needs, for example a soft diet or a culturally specific diet. We saw and people told us that care workers provided a sufficient amount of support to meet nutritional needs in various ways.

We spoke directly with people, looked at records at the office and those in people's own homes to gauge how people's healthcare needs had been met. People told us that care workers had on occasions contacted a GP to carry out a home visit or had encouraged the person to seek advice from their GP. Care plans reflected contact with health and social care professionals involved in people's care if any health or support needs changed.

People's care records included evidence that the service had also supported them to access district nurses, dieticians, dentists and other health and social care professionals based on their individual needs. People had access to healthcare services and received healthcare support, sometimes as a result of intervention or advice from care staff.

Requires Improvement

Is the service caring?

Our findings

People and their relatives were complimentary about the service and about the caring nature of staff. People used words such as 'kind', 'considerate',
'respectful' and 'polite' when describing staff.

The service had received numerous compliments from people, their relatives and health and social care professionals and we saw examples of these in emails. One social care professional provided feedback to the registered manager after doing a review of the care package. The relative of the person receiving care and support had said it taken 'so much pressure' off them as a carer and had improved both their lives 'in every way'. Another person emailed a compliment about their care worker to the registered manager, praising their patience and professionalism and we saw this stored on their personnel file.

However, not all staff were caring and professional in their practice. We visited one person in their own home around lunch time and noted that the communication log reflected that a lunch time visit had occurred just before our arrival. We discussed this with the individual and in our conversation, they told us they had decided they did not need a lunch time visit and had told the care workers this 'a few months ago'. Care workers had not passed on this information to the office, nor had it been raised or discussed with the person's social worker. We also saw from the communication log book that particular care workers were still recording that a lunch time visit was still taking place and that care and support had been provided. We brought this to the registered manager's attention so that they could address these false entries and take appropriate action with the relevant members of staff.

We also saw an example of inappropriate language used to describe a person's mood written in a daily communication log and brought this to the registered manager's attention. Negative or derogatory comments can impact on a person's well-being and staff should be mindful of the language used when recording in care plans. The registered manager had already arranged for some staff to attend specific training to address this learning need.

The service promoted equality and diversity. Equality is about championing the human rights of individuals or groups of individuals, by embracing their specific protected characteristics and diversity relates to accepting, respecting and valuing people's individual differences. Training records we looked at showed that staff had undertaken training in equality and diversity. Company policies and procedures covered the protected characteristics under the Equality Act and these were shared with and made accessible to staff.

Care records we looked at during our inspection, showed that people had been involved in the development and review of their support plans. People had signed to confirm they had been involved and the level of personal information such as, their backgrounds and history, likes and dislikes showed that staff had involved the person. This is important as it makes sure people's views and preferences are taken into account with regards to the delivery of their care.

People considered their privacy and dignity were respected by staff when providing personal care. Staff

provided us with examples of working practices that supported this and people told us they were supported by regular care workers or small teams of staff, which helped them feel at ease. We saw examples of small laminated dignity in care cards that were given to people receiving a service who lived in Salford. These explained to people what they could expect to receive from staff , including being treated as an equal and not being discriminated against. It was not clear if these were given to everybody supported by iCare Solutions – Manchester Limited, which would be best practice.

Staff were aware of the importance of maintaining and building people's independence as part of their role. Throughout discussions with staff they spoke about allowing people to do things for themselves. One member of staff told us, "I prompt them(people) to do as much as they can by themselves and support them when required." This was further supported by people we spoke with. One person told us, "They (staff) help me to be independent. They never rush me." Another person had health conditions which limited the time they could stand up. They told us, "I can't stand for long so it's not possible to help much with cooking but they let me do things like making fresh fruit salad – I can do that sitting down." Care records we looked at detailed the level of care and support a person needed.

Personal records, other than those available in people's homes, were stored securely in the registered office. Office staff had access to those records relevant to them and the areas they covered or managed. Staff files and other records were securely locked in cabinets within the offices to ensure that they were only accessible to those authorised to view them.

Good

Is the service responsive?

Our findings

Support plans were person centred and people confirmed they had been involved in developing these at the start of their care and during any reviews since. Support plans covered many aspects of the person's life, such as, mobility, personal care needs, days and times of visits from staff, any medical conditions including allergies, communication needs and things important to the person, such as family or pets. Support plans provided staff with specific details about how people wanted certain aspects of their care and support provided and aims that people wanted to achieve as a result of having care were documented.

Reviews were carried out by office management staff in conjunction with the person and other interested parties, for example relatives, health and social care professionals. During these reviews the company took the opportunity to gain the person's views about the service and how it might be improved for them. We did see some information on a support plan in a person's home about a pet that was no longer valid. The service should ensure that the whole support plan is reviewed and updated so that all information is current for staff providing care and support.

We could see that people were offered choices in their daily routines wherever possible, including food choices, what they wanted to do, times they wanted to get up or be put to bed. These were recorded in the daily notes logged in communication books. We saw examples of daily notes in people's care records and some were clear and legible. On occasions these were detailed and showed what support the staff member had given during their visit to the person, any specific choices made, for example at mealtimes or when taken out in to the community.

We saw that there was a good mix of male and female care workers employed by the service. The registered manager recognised that the service could offer clients a choice with regards to the gender of the care worker and we saw examples of when this had occurred. The service also tried to allocate staff with shared interests or something in common with the person they were supporting. A social care professional we contacted as part of the inspection told us how the service had 'matched' a person of a particular culture with a care worker of the same culture. They were now able to prepare home cooked food for the person that was traditional in their home country which they really enjoyed. A member of staff we spoke with was able to speak three languages in addition to English and told us how they supported people whose first language was not English. They had been able to reassure and communicate with three people in their first language and this had given people more confidence and made them more receptive to care.

The service managed complaints satisfactorily and according to company policy. We asked staff what they would do if someone wanted to make a complaint. Staff we spoke with were aware of the complaints policy and told us they would inform the office or a line manager if people wanted to make a formal complaint. Informal concerns, for example if a call was too early, were raised with care workers, reported to senior staff and resolved by the office. People we spoke with would have no problem in raising a complaint if they felt this was necessary. Files stored in people's homes we visited contained a telephone number that people could ring if they wanted to make a complaint.

We looked at what technology was used to support people who used the service. We saw that some people the service was supporting had a 'key safe' system in place. This was a system by which a key to the main entrance was placed in a box protected by a passcode. This enabled the staff at the service to access a person's home at agreed times. The registered manager told us they were looking into new equipment for staff by means of a mobile monitoring application; this would enable staff to use their mobile phones to log visits, record visit start and finish times and would mean any missed visits were alerted to office staff in real time so that appropriate action could be taken.

We checked if the provider was following the Accessible Information Standard. The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. The service did have access to a number of large print words and pictures, including days of the week, a clock template to communicate the time and pictures of meals. Staff were not using any of these prompts at the time of this inspection as they weren't needed however the registered manager knew what was available if required.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The registered manager was also registered at another branch of the company, based in Darwen, although most of their time was spent at the Manchester branch. It was envisaged that this would become a separate company in the near future. The registered manager worked alongside the provider, who was hands on in the business. Both were knowledgeable about the corporate and organisational side of the service and the registered manager had responsibility for the four geographical areas that operated from the branch. However, we judged that the service was not always well led and not all aspects of the service were open and transparent.

We noted a lack of consistency between the different areas of the business. For example, not all paperwork was the same across the service. The starter pack we saw for new employees in Salford was thorough and contained good information for staff with regards to dignity in care, although we were not assured that this pack was replicated for new starters across all the company. There were three versions of a supervision matrix, differing slightly across the areas and MAR chart templates were also not the same. We identified risk assessments completed for staff with convictions as being not fit for purpose and we questioned the validity of one numeracy and literacy test completed at interview. We were not assured that the employee had completed this test in which full marks were obtained. One person we visited at home as part of this inspection informed us that they had declined lunch time visits however some care workers were still recording these as if they had been carried out.

This was a repeat breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the registered manager did not have oversight of all aspects of the service and audits had not identified the falsified recordings we saw.

In preparation for the inspection, we checked the records we held about the service. We found that the registered manager had notified CQC of any accidents, serious incidents and safeguarding allegations as they are required to do. This meant we were able to see if appropriate action had been taken to ensure people were kept safe. We had also received the Provider Information Return which we ask providers to complete as part of the inspection process. We looked at what systems and processes the registered manager had in place to monitor and improve the quality of the service. Quality monitoring spot checks were undertaken at least once a year for each person using the service using a company template Property Spot Check Quality Monitoring Tool. This tool covered audits of care plans and other information, medicines records, comments books and also allowed for people using the service to give their feedback.

Similarly, field observation spot checks were carried out to check on staff practice and test staff knowledge about the care and support they provided for individuals. Staff we spoke with and records we saw confirmed these happened.

The provider along with the registered manager were keen to continuously learn and improve the service to ensure its long-term sustainability. Since moving to new premises in August 2017 care provision had expanded to other areas, for example Salford, Swinton and Partington. The low usage of the electronic monitoring system by staff had been a key challenge for the service. To improve this, they had looked at ways of accessing additional technology to link in with current systems and were introducing a more efficient mobile network solution. Policies and procedures were in place and accessible to guide staff in their roles. These had been reviewed and updated as required. We saw a policy in relation to the General Data Protection Regulation (GDPR) had been adopted by the service to reflect the new law around data protection, introduced in May 2018.

Staff we spoke with felt well supported by their line managers and from the registered manager. There was an organisational structure in place which outlined roles and responsibilities within the company. We spoke with office staff representing each area and all felt supported by the registered manager. The different areas worked with a degree of autonomy and each had a lead person, like a branch manager, responsible for the daily running of their own service.

People who used the service told us they were engaged in various ways and were given the opportunity to provide feedback on the service in questionnaires sent out twice a year. We saw examples of completed questionnaires at the office, which were mainly positive. We noted some less positive comments around weekend care and communication with people in the office. No action had been taken as a result of people's responses from the survey as these had not been collated at the time of this inspection.

Staff were not currently given surveys to complete, although the registered manager was working on a staff survey and shared a draft copy with us following this inspection. It is important to listen and gain the views of staff as this can indicate where improvements to the service are needed. Staff were engaged however in other ways, for example in staff meetings, group discussions and supervisions and staff we spoke with valued these involvements. Staff meetings are an opportunity to keep staff up to date with organisational information, service user information and provide a good opportunity for feedback.

There were schemes in place to provide incentives to staff, including a care worker of the month award. Vouchers were awarded on a monthly basis to the care worker who was deemed to have gone 'over and above' in their duties and any compliments staff received from others were taken into account. There was also an increased rate of pay for those workers achieving 75% compliance in logging in and out of calls. The staff we spoke with as part of the inspection felt appreciated and morale was higher than at the last inspection.

We looked at how the service linked in with other agencies and saw good examples of how they worked in partnership, alerting other professionals when concerned for people's welfare in order to improve people's quality of life. There were links with the local authority, district nurses, GP's and health professionals. One local authority had imposed a temporary suspension on the service which meant no new business had been offered to iCare Solutions – Manchester Limited by Trafford council whilst the suspension was in place. The local authority had asked for an action plan to be submitted by the service detailing what would be done to address the areas of the business identified as needing improvement and this had been provided. A quality officer from Trafford council had visited the service prior to our inspection and the temporary suspension had been lifted on 3 September 2018.

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 17 HSCA RA Regulations 2014 Good governance The registered manager did not oversight of all aspects of the service and audits had not identified the issues we found. There was a lack of consistency across areas of the business.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment practices were not always safe. Risk assessments completed for employees with previous convictions were not robust. We were not satisfied that all staff employed were fit and proper persons.