Icare Solutions Wakefield Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
iCare Solutions Wakefield Ltd is a domiciliary care agency which provides personal care to people living in their own homes. At the time of our inspection there were 11 people using the service, this included older people and people living with physical disabilities.

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
Shortfalls identified at the previous 2 inspections had not been addressed by the provider, which led to ongoing and repeated breaches.

Risks to people's health and safety, including infection risks, were still not being adequately assessed, monitored or managed. Medicines were still not being managed safely and we could not be assured people received their medicines as prescribed. The provider continued not to practice safe recruitment when employing new staff members, including when recruiting to management positions.

We have made a recommendation regarding the provider's process for call monitoring.

Leaders were still unable to demonstrate they had the necessary skills and expertise to deliver a safe service. Quality assurance systems were no longer in place, as audits of quality and safety were not taking place and had not taken place since our last inspection. This meant opportunities to drive improvements in the service were being missed. The provider had also failed to establish effective systems for gathering views from people, their relatives and staff.

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 20 December 2022) and there were breaches of regulation.

At this inspection we found the provider remained in breach of regulations.

Why we inspected
We carried out an announced inspection of this service on 09 and 11 November 2022. Breaches of legal requirements were found in relation to safe care and treatment, good governance and fit and proper persons employed.

We undertook this focused inspection to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained inadequate. This is based on the findings at this inspection.

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

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, good governance and fit and proper persons employed 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
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.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review.

If the provider has not made enough improvement 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 Wakefield Limited

Detailed findings

Background to this inspection

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

Inspection team
This inspection was carried out by 2 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.

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 not a registered manager in post.

Notice of inspection
We gave a short period notice of the inspection. This was because it is a small service and we needed to be sure that the provider 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 the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers 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 this information to plan our inspection.

During the inspection
We spoke with 2 people who used the service and 6 relatives about their experience of the care provided.

We also spoke with 9 members of staff including, the nominated individual, the branch manager, the acting branch manager and 6 care assistants. 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 3 people's care records and multiple medication records. We looked at 3 staff files in relation to recruitment. We also looked at a variety of records relating to the management of the service, including policies and procedures.

Inadequate

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 we rated this key question inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to ensure systems were either in place or robust enough to demonstrate safety was effectively managed. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

• Risks to people's safety were still not adequately assessed, managed or mitigated.
• At the last inspection, we found people's risk assessments lacked information for staff to support people safely. The provider had failed to take steps to address this concern and people's risk assessments continued to lack relevant information. For example, we reviewed 3 people's risk assessments and found risks associated with moving and handling, choking and diabetes had not been adequately assessed.
• People's care records and risk assessments contained conflicting information. For example, 1 person's risk assessment stated they did not have a visual or cognitive impairment, but their care plan said they did. This meant staff lacked relevant information to support this person safely.
• Systems were not in place to ensure staff understood risks to people's health and safety. Staff we spoke with consistently told us they did not have access to people's risk assessments or adequate information about people's needs.
• There was a system in place to record accidents and incidents. However, it was not being operated effectively, and the provider did not have oversight. This meant opportunities may have been missed to identify ways of preventing future incidents, and exposed people to the risk of harm.

Systems had still not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. 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 our last inspection the provider had failed to ensure systems were in place to guarantee the proper and safe management of medicines. This was a breach of regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

regulation 12

• Medicines were still not being managed safely.
• We could not be assured people received their medicines as prescribed. For example, we reviewed 2 people's electronic Medication Administration Records (eMARs) and found they contained multiple gaps. This meant there was no record of whether these people had received their medicines.
• Staff were still not being given guidance on how to safely administer people's prescribed creams. For example, we reviewed 2 people's daily notes and found staff were administering creams. However, their care records did not contain any information for staff on how, when or why they should administer the creams. This was an issue at the time of the last inspection and no steps had been taken to address this.
• Audits of eMARs were not taking place and had not taken place since our last inspection in November 2022. This meant opportunities to address the concerns we found at this inspection had been missed.

Systems were still not in place to ensure the proper and safe management of medicines. This placed people at risk of harm. This was a continued breach of regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection the provider failed to establish or operate safe recruitment procedures. This was a breach of regulation 19(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 19.

• Safe recruitment practices were still not being followed.
• When employing new staff, including those in senior positions, the provider had failed to compete thorough checks. This meant the provider had not ensured people employed were of good character and safe to work with vulnerable people.
• This was a concern at the time of the last inspection, yet the provider had not taken steps to address this.

Safe recruitment practices were still not being operated effectively by the provider. This placed people at risk of harm. This was a continued breach of regulation 19(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• Records we viewed demonstrated there were enough staff deployed to meet people's needs. However, the provider had failed to implement a system to monitor the timeliness of people's calls.
• We received mixed feedback from people regarding consistency of staff and their punctuality. Comments included, "It's been quite difficult sorting out whether I get 2 carers, when I was getting 1 carer, and now I don't know who will be arriving", "[Staff] are very late, 5 days out of 7 and can be over an hour late. Sometimes they let me know but normally they do not", "Usually it's up to 4 days a week that calls are very late, and we are not informed" and "Yesterday carers were over an hour late and the office didn't let me know they were running late."

We recommend the provider reviews its systems and processes for monitoring calls.

Preventing and controlling infection

At our last inspection the provider failed to ensure systems were in place to ensure the risks associated with

infection prevention and control were effectively managed. This was a breach of regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

• Risks associated with infection control were still not assessed, managed or mitigated.
• We reviewed 2 people's records at the time of our last inspection and found they did not include an assessment of the risks associated with their catheter care. At this inspection, we found those records had not been reviewed or updated. This meant staff still did not have guidance on how to monitor the signs and symptoms of infection for people being supported with a catheter.

Systems were still not in place to ensure the risks associated with infection prevention and control were effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
• People and relatives told us they felt the service was safe.
• Staff we spoke with could describe and identify different forms of abuse and were aware of their responsibility to report concerns immediately.

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 our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection the provider had failed to establish and operate effective governance systems and processes. This was a breach of regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

• Leaders were still unable to demonstrate they had the necessary skills and expertise to deliver a safe service.
• The service has been rated inadequate for the past two inspections. However, the nominated individual did not have oversight of the day to day running of the service and failed to take action to resolve the shortfalls we identified previously. For example, at this inspection the provider remained in breach of the regulations relating to safe care and treatment, fit and proper persons and good governance.
• We found the provider had still not established their own quality assurance systems or processes. The nominated individual told us they had not carried out any audits of service delivery and they were unaware of the concerns identified at this inspection. This was a concern at the last two inspections, but no action had been taken by the provider to address this.
• We also found no audits had taken place since the time of our last inspection by anyone else employed at the service. This meant the quality and safety of the service had not improved and steps were not being taken to address this.
• The provider's policies and procedures were still not specific to the service, despite this being raised as an issue at the last two inspections. We also found multiple policies and procedures were not being followed. For example, practice in the service meant the good governance, quality assurance, risk assessment and recruitment policies were not being followed.

People were at risk of harm as governance systems and processes had still not been fully established or operated effectively. This was a continued breach of Regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality

characteristics
• The provider had failed to establish effective systems for gathering views from people, their relatives and staff.
• We found no evidence feedback had been gathered from people or their relatives since the last inspection. People and their relatives consistently told us they were not asked for feedback on a regular basis, but when concerns were raised, no improvements were made. For example, one relative told us, "I made a complaint to the manager and [nominated individual] concerning medication not being recorded correctly and lateness of the manager, when working as a double up. Plus, I complained about the manager's rudeness when I spoke to them on the phone. Nothing changed."
• The provider did not have appropriate systems in place to engage with staff. For example, there had not been a staff meeting since the time of our last inspection and staff told us that they were now unsure who to raise concerns with, as the branch manager had recently left.
• This meant opportunities to improve people's experience of using the service had been missed and staff had limited opportunities to provide feedback about the service.

The provider failed to seek feedback from relevant people, for the purposes of continually evaluating and improving the service. This was a further breach of Regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• The provider did not promote a positive, person-centred, or open culture.
• We received negative feedback about the management of the service from people and their relatives. Comments included, "The problems have always been with the manager. To me [the manager] didn't manage or have the leadership skills" and "It's terrible. The service is run up and down."
• Staff we spoke with told us they enjoyed their jobs, but we received negative feedback about the support they received from management. Feedback from staff included, "I couldn't say I feel supported, or appreciated, or anything like that", "I don't know who the managers are at the minute because they keep swapping and changing" and "[Nominated individual] is never to be seen."
• During this inspection the branch manager left, which staff told us had impacted on morale.

Working in partnership with others
• People's care records showed the service worked in partnership with other agencies who were involved in people's care and support. However, records were not always updated to reflect when people had received input from health and social care professionals. For example, 1 person's care records referred to the need for a review by the district nurses, but their records had not been updated to demonstrate whether this had taken place. We therefore could not be assured this review had happened.

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
• We found no evidence incidents had occurred which would require the provider to follow their duty of candour policy.
•The provider's policy was suitable, although it had still not been tailored specifically to the service. This was raised as an issue at the last inspection and no action had been taken to update it.