We Care Solutions Manchester Limited

We Care Solutions Chorlton

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
We Care Solutions Chorlton is a domiciliary care provider based in Manchester and provides personal care to adults and older people in their own homes. At the time of our inspection the service supported 152 people. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
People's visit times were cut short, and visits were frequently late. This impacted negatively on people's experience of their care. There was a failure to assess and identify the risks involved in the delivery of care to people. This put people at risk of harm and poor care.

The service had failed to raise standards since the last inspection. A poor management culture provided poor oversight of the service. Late visits and call cramming had become the norm. Poor care planning processes and procedures put people at risk of unsafe care. The service was not person centred and dealt poorly with people's complaints.

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

The last rating for this service was requires improvement (published 16 July 2019) with breaches in Regulations 17 (Good governance) and Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This service has been rated requires improvement for the last three consecutive inspections. 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 Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and a further four regulations.

Why we inspected
We received concerns in relation to missed visits, late visits and the management of catheter care, choking risks, care planning and medicines. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

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

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

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 five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, namely Regulation 9 Person-centred care, Regulation 12, Safe care and treatment, Regulation 13, Safeguarding service users from abuse and improper treatment, Regulation 17, Good governance and Regulation 18, Staffing. This is the fourth consecutive inspection in which this service has been in breach of regulations.

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 work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore 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 of 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.

We Care Solutions Chorlton

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 carried out by four inspectors and one 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 did not have a manager registered with the Care Quality Commission in line with the requirements of the provider's registration. A registered manager had not been in place since the last inspection. The service had a manager who was also the provider. This means they are legally responsible for how the service is run and for the quality and safety of the care provided with the Care Quality Commission.

Notice of inspection
We gave the service 1 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider/manager would be in the office to support the inspection. Inspection activity started on 16 June and ended on 25 June. We visited the office location on 16 June.

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. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all this

information to plan our inspection.

During the inspection
We spoke with fourteen people who used the service and seventeen relatives about their experience of the care provided. We spoke with fourteen members of staff including the provider, manager and care workers.

We reviewed a range of records. This included twelve people's care records and multiple medication records. We looked at four staff files in relation to recruitment and training. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment
At our last inspection robust procedures were not always followed to ensure staff employed were of suitable character. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 19.

- Staff recruitment records demonstrated the service was ensuring staff were subject to the appropriate scrutiny to ensure they were of good enough character to work with vulnerable people.
- The organisation of people's visits was not managed safely. Systemic call cramming meant people did not get their allocated time for visits and this put people at risk of not receiving safe care and treatment. People also told us their visits were frequently late. Comments included, "It seems they are working around clients to fit everyone in rather than the needs of people" and "The weekends can be a nightmare. I am constantly ringing the duty number… The problem is (relative) won't have his breakfast until he is sorted and comfortable. We give him his painkillers before they are due to come so it is easier for him and by the time, they arrive they are wearing off. Plus, he is laid in his wet clothes and it isn't fair or dignified for him…even after she promised Sunday, they were still late."
- Late calls were more frequent at weekends and impacted negatively on people's care as people were not aware when the carers would arrive. One person's catheter bag overflowed as a result of one late visit and they were also unable to take their insulin at the correct time as they had not been supported to have their breakfast.
- Staff did not get allocated travel time between care visits, with some staff working in excess of sixteen hours a day with no allocated breaks. A number of people and their relatives told us that their care visits were rushed at times, "The staff do the best they can, but always rushing, I feel sorry for them. I have had to tell one carer to slow down as she was rushing my care."

There was a failure to deploy staff safely. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
- Staff did not manage medicines safely. This put people at risk of harm.
- Staff had not received regular medicines training and competency assessments before they provided support to people with their medicines.

● Staff did not keep accurate records of the medicines they administered. Monthly audits had failed to correct an issue where staff were using different recording systems. Staff administered the wrong medication to one person as a direct result of poor recording.

Poor medicines recording put people at risk. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management, learning lessons when things go wrong
● There has been a repeated a failure to thoroughly assess and identify risks involved in the delivery of care to people since the last inspection. Staff lacked adequate guidance to safely manage risks. This put people at risk of harm.
● There were no risk assessments in place for people with catheter care. Care planning had not considered the risk of infection and there was no information about potential warning signs, such as blood in the catheter bag or signs of infection, for example. There were several examples of poor catheter care including one person who had blood in the catheter and was admitted to hospital to receive treatment for sepsis. A new catheter care policy was introduced after the inspection.
● The assessment and management of people's diets placed them at risk of choking or aspiration. There were no risk assessments in place in people's care plans to manage such risks and the information in care plans was not always correct which increased the risk of one person choking.
● People were at risk of developing pressure sores. One person had previously received hospital treatment for pressure sores and was still at risk. Staff had no guidance in the care plan or risk assessment to help manage this risk.
● There had been a failure to escalate concerns to relevant bodies to help keep people safe. The potential impact of care that was not delivered was not understood. For example, one person had missed five successive evening visits. The missed visits were not escalated to other relevant health and social care agencies and resulted in the person needing a hospital admission.
● There were insufficient systems in place to ensure incidents were thoroughly investigated, reported, reviewed and monitored to prevent further occurrences. The service did not ensure lessons were learned when things went wrong and did not have systems in place to ensure reported safety concerns were addressed. For example, one person injured themselves during a moving and handling procedure due to this not being safely done by two staff members. The manager's investigation letter to the person said staff would be trained in the use of equipment. We found this did not take place.

Failure to provide safe care and treatment by not managing known risks to people puts them at an increased level of risk. This is a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Poor record keeping and a failure to have effective systems in place to review and learn from incidents made poor care more likely. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● The manager was not always clear about when to escalate concerns to the local authority and when to submit notifications to the CQC. This put people at increased risk, as the local authority had not been made aware of concerns where people were at risk of self-neglect, for example.
● Staff and the provider did not have an in-depth understanding of safeguarding and more training and development in this area was required which had been planned by the provider. The staff we spoke to did not have a good understanding of safeguarding. This increased the risk of abuse going unreported as staff

were not clear about their responsibilities.

Systems were in place but not operated effectively to keep people safe from harm or abuse. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● Care staff had been provided with updated infection control training and had access to the correct Personal Protective Equipment (PPE) to protect them and others from the spread of infection. People told us that staff wore the correct PPE and that they felt safe.

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 requires improvement. At this inspection this key question has now deteriorated to 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 the last inspection in May 2019 we found the provider had not established robust systems and processes to assess, monitor and improve the quality and safety of the service.

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

At this inspection we found that the provider had not made the improvements needed and the service was still in breach of this regulation.

● There were widespread and significant shortfalls in the way the service was led. There has been no registered manager in post since October 2019, however, the provider had submitted an application in February 2020 and this was still being considered at the time of inspection.
● The service has repeatedly fallen below the minimum regulatory standards required to ensure the vulnerable people in the provider's care received their care and support safely. The previous three inspections have resulted in the service being rated requires improvement and there has been a failure to assess, monitor and improve the quality of the service since it was first rated requires improvement in 2017.
● There was continuing evidence that the management of risks within the service was not adequate. Complete and accurate records relating to the administration of people's medicines were still not being maintained. There was continuing evidence that assessments of people's risks were still not being carried out or documented in people's care records. This meant staff did not have the guidance they needed to refer to when carrying out their roles and this put people at high risk of receiving unsafe and inappropriate care.
● The framework for quality assurance was not operating effectively. The monthly audits in place were too narrow on their own to deliver what was required to drive improvements within the service, and there was limited evidence provided of any analysis and actions taken to date to improve the service.
● The provider was not delivering safe care and treatment. Poor care planning processes and procedures put people at risk of unsafe care. Pre-admission assessments were not recorded to ensure that people's needs could be safely met before a plan of care commenced. These assessments are vital to ensure people's needs can be met safely.
● Staffing was not safe. Systemic call cramming put people at increased risk of receiving poor care. This was evident in the staff rotas where late visits had become routine.
● The provider had a poor understanding of regulatory requirements. Services providing health and social

care to people are required to inform the CQC of important events happening in the service. This is so we can check appropriate action has been taken to keep people safe. The provider was not clear about when to submit notifications therefore we could not be confident that all notifications had been submitted. These were often late when they were submitted.
● Record keeping in relation to people's daily care lacked detail, completeness and was frequently illegible.

The provider had not established robust systems and processes to assess, monitor and improve the quality and safety of the service. This was a continued breach of Regulation 17 (Good governance) 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 had failed to create an empowering, open and person-centred culture. People were not consistently receiving a good service which meant good outcomes for people were not always being achieved.
● The organisation of the staff rotas demonstrated a disregard for people's needs and resulted in a culture that accepted late visits as the norm.
● There was a long hour's culture where staff worked long days without scheduled breaks. The number of scheduled visits meant staff had to cut visits short to ensure all visits were completed. This put people at increased risk as staff were rushing.
● The assessment process was not person centred. People's needs were not always clearly established before care was provided and this put them at risk. For example, one family told us that they had to write a task list as the carers were unaware of the person's needs.
● There was a lot of negative feedback about the service. People and their families told us, "The times at a weekend are atrocious, for example, in the week they are here by 9 am at a weekend it is never before 10" and "[Relative] finds it mentally draining. There is only so much [Relative]can take. [Relative] is fed up. Working with this agency is like a full-time job, it is really stressful."

People were not receiving timely, appropriate, personalised care and support to meet their needs. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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
● Investigations into people's complaints or concerns were of poor quality and did not fully address their concerns . People told us, "The manager did not reassure me, he wound me up instead. I cannot trust them. The management is terrible" and "I have been ringing and complaining about the lateness at weekends for weeks and get the usual platitudes, but nothing has changed."
● The provider did not prioritise service improvement effectively in response to the concerns raised.

The provider did not listen to and act on people's feedback appropriately. This was a breach of Regulation 17 (Good governance) 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; Working in partnership with others
● The provider told us they carried out annual surveys with people to find out their experience of the service. This helped them to identify areas of concern and areas to improve.
● Staff told us they felt supported and felt confident to contact the office if they had any concerns.

● The service needed to work more closely with other health and social care professionals. For example, a more consistent approach was needed to make social workers aware of issues of concern that arose in relation to people's care packages.