ICare Solutions Manchester Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected ICare Solutions Manchester on 12, 16 and 20 December 2016. The first day of inspection was unannounced. The second day was spent visiting people in their homes who received a service and the third was spent back in the office providing feedback to management.

ICare Solutions is a domiciliary care service providing personal care and support to people living in their own homes. The service also works closely with healthcare commissioning teams in supporting people who have a range of healthcare needs. The hours of support vary depending on the assessed needs of people.

At the time of the inspection the service was supporting 75 people within the local community of Manchester and Stockport. We last inspected the service on 1 May 2014 when we found the provider was non-compliant in Regulation 12 of the Health and Social Care Act 2008.

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.

People told us they received safe care, which was reliable and consistent. The service had sufficient staff to meet people's needs, and people were given the time they needed to ensure their care needs were met.

We saw that people were protected from avoidable harm. During the inspection we checked to see how the service protected vulnerable people against abuse and if staff knew what to do if they suspected abuse. There was an up to date safeguarding vulnerable adult's policy in place. Risks to people were assessed and risk management plans were in place. We found that the staff we spoke with had a good knowledge of the principles of safeguarding.

Risks posed to people were identified during the assessment process. Care plans we looked at contained information in relation to risks that had been identified for individuals, for example when mobilising or having medicines. Environmental risks had also been identified and documented for staff.

Staff were trained to administer medicines. The registered manager was in the process of implementing a more thorough Medication Administration Record (MAR) chart for more accurate recording of medicines. The management team acknowledged that the medicines management system could be more robust and agreed to re-visit their policy, ensure this was aligned to best practice and implement any changes they needed to make the system safer.

The service was not working to the principles of the Mental Capacity Act, 2005 and staff did not receive any formal training on MCA. The service was not assessing and documenting, where necessary, people's ability to consent to care.

The service had robust recruitment processes which included the completion of pre-employment checks prior to a new member of staff working at the service. This helped to ensure that staff members employed to support people were suitable and fit to do so. People who used the service could be confident that they were protected from staff that were known to be unsuitable to work with vulnerable people. Staff knew their roles and responsibilities and were knowledgeable about the risks of abuse and reporting procedures.

We saw evidence of the induction process and there was on going training provided for caring roles and responsibilities.

People were supported with a range of services which enabled them to continue to live in their own homes safely. People we spoke with who used the service and their relatives told us they had been involved in the assessment and planning of the care and support provided and that the service responded to changes in people's needs.

The care records contained information about the support people required. We saw documented evidence of people's likes, dislikes and preferences and records we saw were complete and up to date.

We found from looking at people's care records that the service liaised with health and social care professionals involved in people's care if their health or support needs changed. The service worked alongside other professionals and agencies in order to meet people's care requirements.

Likes, dislikes and personal preferences of people using the service were documented in care plans. People had been consulted and the service recognised the importance of documenting this information so that care and support provided was personalised, safe and correct for the individual.

There was an up to date accident/ incident policy and procedure in place. Records of accidents and incidents were recorded by care workers within communication books, however these were not always actioned at the office. The recording of accidents and incidents needed formalising.

The service had a complaints policy in place and we could see that people using the service were aware of how to make a complaint. Formal complaints were acknowledged and addressed within specified timescales.

Staff told us they felt they were able to put their views across to senior staff and to management and we saw examples of this from minutes of meetings and supervision records. The staff we spoke with told us they enjoyed working at the service and said they felt fully supported and listened to.

The service did not undertake spot checks on staff to observe behaviour and practice and the formal audits in place to monitor the quality of service delivery were not limited and ineffective. Feedback from people using the service and their relatives was gained via various sources. The service could evidence that it had acted on feedback to improve the care experience for people.

The overall rating for this service is 'requires improvement'. During this inspection we found two breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. You can see what action we have 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

Accidents and incidents were recorded by care workers. It was not always clear if these had been reported to the office and whether any further action had been taken.

Staff were able to describe the action they would take to protect people if they were concerned people were at risk of harm or abuse.

Medicines were being administered according to company policy. However, we found instances where the medication administration record had not been completed, to indicate medicines had been safely administered. A more robust document for recording medicines administered was being rolled out by the company.

Is the service effective?

Requires Improvement

The service was not always effective.

The principles of the Mental Capacity Act 2005 were not being followed. There were no capacity assessments on care plans and consent to care was not managed appropriately.

Staff received mandatory training in relevant aspects prior to starting employment.

Supervision was consistent for all staff. Staff were given the opportunity to raise any concerns about individuals they were supporting.

Is the service caring?

Good

The service was caring

People and their relatives told us they were supported by staff who understood their needs.

Care staff we spoke with demonstrated their understanding of how to maintain people's privacy and promote dignity.

People were encouraged to maintain their independence.

Is the service responsive?

Good

The service was responsive.

The provider delivered care that was responsive to people's individual personal preferences.

The service was flexible and responsive to people's individual requests.

Complaints and concerns had been investigated and resolved to people's satisfaction.

Is the service well-led?

Requires Improvement

The service was not always well led.

The system of quality checks and audits in place was ineffective therefore improvements were not always identified or implemented.

Staff felt supported by the registered manager and they felt listened to.

The service had a positive culture and wanted to develop. Feedback from people using the service and their relatives provided evidence of improvements the service had made.

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.

This inspection took place on 12, 16 and 20 December 2016 and the first day was unannounced. The inspection team consisted of one inspector 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.

The inspection included visits to the home care agency's premises, to people in their own homes and the expert by experience made telephone calls to six people who used the service and four relatives to find out their views on the care and service they received.

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.

As part of the inspection we reviewed the information we held about the service. This included contacting the care commissioners in Manchester 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.

During our inspection we spoke with the registered manager, a care coordinator, a director of the company and seven care workers. At the time of our visit the service was providing personal care and support to 75

people.

We spent the first day of the inspection at the service's registered address speaking with staff and looking at records. These included five people's care records, five staff recruitment files, staff training records, supervision records, various policies and procedures and other documents relating to the management of the service.

On the second day of inspection we visited four people who used the service in their own homes and spoke with one relatives. We looked at paperwork relating to their care after obtaining the individual's permission.

Requires Improvement

Is the service safe?

Our findings

We asked people using the service and their relatives whether they felt safe when the care staff were visiting. People and their relatives had good things to say about the service. They said, "Yes, I do feel safe"; "My relative is kept safe; there's always two carers to use the hoist" and
"I have one carer. She makes me feel safe."

People who used the service and the relatives we spoke with during the inspection were aware of who to speak with should they need to raise a concern. They told us they felt safe and trusted the staff who helped to provide them with the care and support they needed. Some of the people using the service were supported with their medicines and plans of care outlined what level of support people required. Staff had received training on how to support people to manage their medicines. This support was generally provided by prompting or reminding individuals to take their medicines, however some packages of care required staff to administer medication. Company policy stated that where staff administered medicine in tablet form this was done from blister packs prepared by a pharmacist and the person's Medication Administration Record (MAR) chart was then completed and signed by staff.

We spoke with people who used the service who needed support from staff to administer their medicines. People did not report any problems and advised care staff were reliable. One person said, "I have help; they give me my tablets in a morning and then they sign the book." One person we spoke with was able to self-administer medicines. They told us that staff always asked if this had been taken. This meant that even when staff were not responsible for medicines administration, people were reminded to take them and kept safe from harm.

When we visited a person in their own homes we looked at their care plan, after being given permission to do so. We saw that their tablets were blister packed and were being administered according to policy. Staff were not always accurately recording on the MAR chart but were writing that blister packed medicines had been administered in the communication book. A record must be kept of all medicines administered to the person the service is caring for using the right paperwork. This information is an audit trail and is vital to other care workers who visit the person as they could administer medication incorrectly causing harm to the person.

We saw that the registered manager was dealing with a recent complaint around the administration and recording of medicines. Specific instructions had been issued to all staff involved in the care package and a more detailed MAR chart had been devised and placed in the property. This was an improved recording method and the registered manager told us this would be adopted across the company. We discussed with the registered manager how the medicines management system could be more robust and they agreed to re-visit their policy and ensure this was aligned to best practice and implement any changes they needed to make the system safer. We will check on this at our next inspection.

We asked people and relatives if they received support from the same care worker or same group of workers. People told us that initially they were visited by several different care workers but this improved once the

care package was established. A relative we spoke with said, "[Person's name] always has the same two carers except on their days off." Another told us, "At first they changed the staff but now I just have [staff member's name]." This meant that people were likely to know their care workers well and this could potentially affect how safe they would feel.

Staff confirmed they had access to an on-call system where they could seek support and help in an emergency. We saw details of an accident recorded in a communication book archived at the office. What wasn't clear however, were the actions taken, if any, as a result of reported or recorded accidents or incidents. One person had been found with a cut to their eye by a care worker. This had been recorded in the communication book in the person's home; how it had happened and what the carer had done. It was not clear if this had been reported to the management team and there was no record of this at the office, nor any notes on the computer system, for example whether relatives had been informed.

Staff we spoke with were aware of the process when reporting accidents or incidents and they told us this was covered during induction and revisited in supervision sessions. We discussed this will the registered manager, who informed us that staff would be reminded of the process and care coordinators made aware to identify any accidents or incidents when auditing communication books and to follow any up with care workers. We will check on this at our next inspection.

Staff we spoke with demonstrated that they knew how to keep people safe and gave us examples of how they did this, such as making sure the person's environment was free from trip hazards; that doors were closed and locked and key safes used appropriately.
We saw the service had safeguarding and whistle blowing policies and procedures in place. These outlined to staff what action they needed to take if they suspected a person was at risk of abuse from anyone. We asked the care workers we spoke with to describe the forms of abuse people using the service might be vulnerable to and they could. Care workers also said they would report any suspicions of abuse to the managers. One care worker told us, "If something isn't right then I report it to [registered manager's name]."

Staff we spoke with told us they had done safeguarding training and training profiles we saw reflected this. Staff were able to give examples of types of abuse and knew what steps to take to report allegations of abuse. Care workers did report concerns they had about the people they supported to the registered manager and this was further evidenced in records we saw at the service. This meant that care workers were vigilant in terms of identifying and reporting any concerns they had regarding the people they supported.

During the inspection we looked at the recruitment records of five staff to check the registered provider's recruitment procedure was effective and safe. We checked the service's recruitment procedures to see if staff employed in the service were suitable to work in the caring profession. The personnel files we looked at contained appropriate documents in relation to the recruitment process including the original application form, written references, proof of the right to work in the UK and copies of photographic identification. All files we checked had a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and aims to prevent unsuitable people from working with vulnerable groups. This meant that people were protected from being supported by staff judged unsuitable to work with vulnerable people.

We saw that environmental risk assessments had been identified and completed for people using the service and were on care plans where applicable. Examples of environmental risk assessments included various aspects of the home environment, such as the kitchen, stairway and any animals in the property. This meant that the service was aware of environmental risks when providing care to people in their homes and had assessed and documented them appropriately.

Other risks posed to people were identified during the assessment process. Care plans we looked at contained information in relation to risks that had been identified for individuals, for example when mobilising or having medicines. One care plan noted that the person had mobility issues and specific equipment was used to assist with moving and handling. The risk assessment outlined what carers were to do and how to do it, ensuring the equipment was fit for purpose and safe to use. This informed care staff about the risk, how to manage the risk and assist the person to mobilise safely which meant that the person received the correct support and was kept safe.

Electronic call monitoring was being used by the service at the time of our inspection. The service provided care in the areas of Manchester and Stockport. Stockport local authority insisted on the use of electronic call monitoring by domiciliary care providers and we saw that usage by care workers in this area was high. This was being adopted in the Manchester area and we saw evidence that the manager was keen to promote electronic call monitoring with clients and their relatives, pointing out the benefits of its usage. When used correctly electronic call monitoring evidences to the commissioners of services that people are receiving correct levels of care as identified within care plans . It also assists the provider in monitoring quality aspects of the service, for example continuity of care and the punctuality of care workers.

If the service identified, or were made aware of, any timing issues with any calls undertaken people told us they were notified of this. We spoke with a person using the service who told us, "If they are going to be late they let me know. [It's] very rare they are late." We saw evidence that the service had refused packages of care offered to them by commissioners. The registered manager told us that if the service did not have the resources to undertake all visits as per the care plan then these were declined. This assured us that people's safety was being maintained.

All the people using the service received assistance from care workers with their personal care, for example, with washing and dressing and continence. We asked people and their relatives if care workers used personal protective equipment, such as gloves and aprons, when assisting with personal care. All of the people we spoke with said that care workers did use gloves and aprons. Staff we spoke with confirmed they always had access to personal protective equipment and we saw supplies of these in the office during our inspection. This demonstrated that staff were aware of infection control and took measures to prevent cross-infections occurring.

Requires Improvement

Is the service effective?

Our findings

People we spoke with and their relatives told us that the service was effective; they trusted the care staff and considered that they had the right skills and attitude for the caring role. People using the service told us, "The carers I have now are ok" and "I'm really pleased with this service."

People using the service told us that carers went over and above what was required of them. They told us, "My two carers are brilliant; [they] do more than they should" and another told us that carers did little extras, for example they tidied up and made sure their mobile phones were fully charged. "If they see my bin bag full they take it out." This showed us that care was person centred and effective for individuals.

The service provided care and support to people who sometimes lacked capacity to make certain decisions for themselves. We looked at what consideration the service gave to the Mental Capacity Act 2005 (MCA) and checked whether the service was working within the principles of MCA.

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.

We saw signed consent forms on care plans indicating agreement to receive assistance with medicines. These had been signed by people receiving a service but we saw instances where these had been signed by family members. Family members must have 'lasting power of attorney' for health and welfare decisions before they can consent for the person. When this is in place it indicates that a person has delegated the responsibility to their relative to act on their behalf. We saw no evidence on file to indicate that relatives or representatives that had signed consent forms on behalf of individuals had Lasting Power of Attorney. This information is essential to ensure that decisions made on behalf of people are lawful. The service was not assessing and documenting, where necessary, people's ability to consent to care.

Some members of staff we spoke with were not confident with the Mental Capacity Act 2005 and all staff we spoke with were not able to describe any restrictive practices that might occur in people's homes when providing care. Two members of staff told us, and electronic training records confirmed, they had not received formal training in this area. The registered manager indicated that an element of the safeguarding training completed on induction informed employees about restrictive practices and coercion, however as staff were not able to demonstrate knowledge in these areas this training was ineffective.

No assessment of capacity was undertaken or recorded during the initial assessment process. Where people did not have the capacity to make decisions we saw no best interest decisions recorded in care plans. This meant people who did not have capacity were at risk of receiving support not agreed in their best interests. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff we spoke with told us they had a thorough induction. The induction and on going training was a mixture of e learning, classroom based study and on site shadowing. The provider ensured that staff completed all aspects of mandatory training and shadowed more experienced colleagues before providing personal care unsupervised so that care was safe and effective.

We saw copies of training records held electronically by the service. These records indicated the training staff had undertaken to date, including mandatory training in safeguarding, medication administration, moving and handling and health and safety. Staff we spoke with were complimentary about the training on offer. One staff member told us, "They [the company] provide any training I need; I've never been refused any." Another said, "Yes I do feel confident and I do get enough training." We were assured that staff were adequately trained and competent to do all the tasks that were required of them, however the provider had not ensured staff received adequate training on the MCA.

Supervision sessions were undertaken by the registered manager every three months and staff confirmed that these were happening. Supervisions provide an opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and learning opportunities to help them develop.

We saw that supervisions covered aspects of care, training and travel time. Staff were given the opportunity to raise any concerns about individuals they were supporting. Staff we spoke with found these sessions with their manager useful and they told us they could raise any personal concerns they had too. Any identified training needs were discussed during these meetings and opportunities for personal development could be raised. Staff we spoke with confirmed they had also had an appraisal during the last twelve months.

The majority of staff we spoke with understood the need for consent from a person prior to carrying out care tasks. One staff member told us, "I would ask them what they want me to help them with; get their permission to do it." Another provided a more detailed example linked to the caring role and told us, "You can always advise people about eating more healthily and drinking more in the day, but if they choose not to there's not a lot you can do." They went on to tell us, "If someone was at risk I would tell my supervisor and the district nurse." We were assured that staff understood the need for consent but would also take appropriate action if they considered a person was at risk.

The service provided support to some people at meal times. Those people who were able were encouraged to be independent in meal preparation and the choice of food they wished to eat. One person told us "I get choices in what I want to eat." We saw that there was a food diary in place when this was warranted and staff logged the provision of meals and drinks to ensure the right diet was being followed. Staff we spoke with showed knowledge of diets specific to people's culture, for example Halal and physical conditions such as diabetes.

The registered manager and staff we spoke with during the inspection told us they worked with other healthcare professionals to support people. The registered manager told us how they communicated with social workers, occupational therapists and hospital staff as part of the assessment process and on going care. Staff we spoke with confirmed they would contact the office and escalate it if they felt someone was at risk or warranted a GP. This meant people were supported to maintain good health and relevant professionals were involved in their care.

Feedback we received from a commissioner of services was positive. They acknowledged that the registered manager was trying to meet the demands and high expectations of people and their families in the delivery of care, fostering good communication with people, relatives, professionals and commissioners of care.

Good

Is the service caring?

Our findings

People we spoke with or visited as part of the inspection process were very complimentary about the service and spoke very highly of the caring nature of staff. One person told us about their 'brilliant carers' who went the extra mile. A person we visited told us about their initial reluctance to have support and said, "I was dreading getting carers. [It's been] exactly the opposite. They make me feel comfortable." A relative told us, "They are caring, compassionate and understand her needs; very happy."

The registered manager told us there was a person centred approach to the support and care people received and we saw this was evident during our visits to people's homes who used the service. One person we visited told us, "I used to tell them what to do, but now they know my routine. They always ask my permission." Staff spoke with kindness and compassion and were highly committed and positive about the people they supported. A member of staff told us, "I'm there to meet their needs, not mine." This showed us that staff put the needs of the person first.

During a visit to one person using the service we observed warm interactions between staff and a person they supported. The person told us how they had been involved in choosing their own support team. On their request an extra male carer had been recruited to the team as this was their preference. Since then they considered that the support had improved. Staff on duty at the time of our visit clearly had a positive relationship with the person. One of the support workers had a shared interest with the person and we heard friendly banter between the two around this shared passion.

Staff knew and understood the individual needs of each person, what their likes and dislikes were and how best to communicate with them so they could be empowered to make choices and decisions. One person we visited was very complimentary of the care they received. They told us, "Things have to be done in a certain way. They know how I like things done."

One person told us that staff took practical action to ensure they were comfortable until the next scheduled visit and checked the person was okay before leaving. The person told us they were reliant on support for all movements so it was imperative they were safe and comfortable before the care worker left. This meant that staff involved the person when delivering care wherever possible and acted compassionately when providing care for those most vulnerable.

Care workers treated people with dignity and respect. Staff we spoke with provided us with examples of how they maintained a person's dignity and offered respect. They told us about closing curtains and doors before providing personal care and making sure people were covered up as much as possible whilst personal care was provided. A person we visited confirmed how their carers put dignity and privacy into practice. They told us, "I have a dignity towel; they cover me when I'm getting undressed. It's part of my beauty regime." It was apparent that this was very important to the person and carers maintained this. A relative we spoke with also considered practice to be dignified. They told us, "[Person] has never felt threatened and her dignity has never been compromised. She would tell me."

Staff supported people and encouraged them to be as independent as possible. One member of staff indicated that they would always ask the person if they needed help. "I always check with them [if they need help]. They might be able to do it themselves or they might want to try."

Another staff member told us they would also give people the opportunity to do things for themselves. They said, "It's [independence] important for some people." This was supported by what a person using the service told us. When asked if care workers let them do things for themselves they replied, "Yes they let me do things. I'm encouraged to be independent. I can transfer myself into a chair." They told us they sometimes helped to prepare a meal. This showed us that staff involved the person when providing support and encouraged them to maintain life skills wherever possible.

One person we spoke with had an advocate and was in the process of appointing another. Staff were assisting with this at their request. This meant that people had access to independent representatives who could act on their behalf and voice their opinions and wishes.

As part of our inspection we visited the offices of ICare Solutions. We found that electronic and paper documents were stored securely and the appropriate checks were in place to ensure that confidentiality was maintained for the people using the service. A person we spoke with told us, "I have a good chat with them [the carers]; they never gossip." This showed us that people trusted the carers and considered they maintained confidentiality.

Good

Is the service responsive?

Our findings

The registered manager of ICare Solutions undertook visits to people prior to them receiving a service and carried out an initial assessment of need. We could see that information had been gathered from a variety of sources including commissioners of care, the individual and relatives prior to care visits being undertaken. This was to ensure the service would be able to meet the person's needs.

We viewed five care plans at the service's office and also looked at three care plans in people's home after obtaining their permission. The care plans mapped out what was expected of carers at each visit and included aspects of care in relation to skin integrity; mobility; continence care; medication and eating and drinking for example. We asked people and their relatives if they had been involved in the assessment and development of their care plans and people told us they had. One person said, "At the start there was a full assessment and I was fully involved." This showed us that people and their relatives were consulted so that needs could be identified and met.

One person we visited told us that senior management had visited them whilst in hospital and had carried out a full assessment. This meant important information about how they would like their support to be delivered was captured in the care plan for staff to follow. On discharge from hospital the care package had started. They told us, "In the beginning there were teething problems but now they have vanished."

The manager emphasised that the service did not take on packages unless staff were available and the particular needs of the person could be safely met. People who were using the service told us that the staff team were consistent on the whole. We saw electronic call records and timesheets relating to the service and people's preferences for call times were recorded in their care plans. We could see every effort was made to ensure people received support at their preferred time. The registered manager told us there was enough staff to meet people's needs and people we spoke with supported this.

People told us the service was able to respond to requests they made to vary or alter the timing of the visits, for example if they had a prior engagement, a hospital or other appointment. One person we spoke with told us how they were able to change the days or times of support if attending school functions. Another person told us that care workers made an additional visit on Friday afternoon to light a candle. This meant that the person's beliefs and customs were acknowledged and they were assisted to continue with practices appropriate to their faith.

People did tell us that they were able to make choices about how their care was provided and delivered and that staff respected their decisions. Staff were able to provide examples of the choices people were given when receiving the service. One person we visited did not want a care plan in the property and this wish had been respected by the company. A care plan was kept in the office and care workers updated it accordingly. The person told us, "That was my decision. I've been treated really, really well. They [the manager] said it's up to you; it's your choice." This showed us the service was flexible and responsive to people's individual requests.

Reviews on care plans were undertaken by the provider on an annual basis although a care coordinator we spoke with told us that this could be sooner if a change in need was identified. During a review of care the provider discussed the current care package, any medical changes and noted any comments made by the person or interested parties present at the review. Relatives we spoke with confirmed their involvement in reviews and told us, "The reviews are every one to two years and we are always invited."

Likes, dislikes and personal preferences of people using the service were documented in care plans. People had been consulted and the service recognised the importance of documenting this information so that care and support provided was personalised, safe and correct for the individual. There were no personal profiles on the files we looked at but we saw evidence of people's interests and social activities recorded in care plans. We were assured by people and their relatives that they considered the service to be good and care staff knew what was required.

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 instances where this had occurred. As well as gender preferences the provider tried to 'match' people and their care workers, either by culture or by shared interests. One staff member we spoke with was confident in her role and commented that this was because they supported someone from the same cultural background.

Similarly when care worker 'matches' had not worked the service tried to put this right. One person we spoke with told us, "I told [person] about a staff member who was unprofessional. It got sorted straight away. I don't have them anymore." Another person we visited had been allocated a care worker with a different faith. The person told us the staff member created obstacles that restricted the individual in following their faith. This was mentioned to management at ICare Solutions and the care worker was replaced. The person told us the current care worker was a big improvement and provided lots of assistance.

The service had an up to date complaints policy and procedure which encouraged people to raise any concerns they may have about the service. People told us that they knew about the service's complaints procedure and would use it if required. We saw that the complaints Some people we spoke with said they never had cause to make a formal complaint or raise a concern.

We saw that a recent complaint, made in November 2016, had come from a family member of a person receiving a service. The complaint expressed concern about poor recording of medicines and the time spent providing care and support.

We saw that the provider had taken appropriate action in relation to the complaint, having investigated the incident and put measures in place to reduce the likelihood of further errors. The new process had been communicated to all staff in the form of a memo. We were provided with email correspondence that had been sent to the complainant outlining the actions taken and conveying the provider's apologies. This meant that the service was effective in ensuring people and their relatives were aware of the complaints process and that systems were in place to deal with any complaints made.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. We asked people and their relatives if they thought that ICare Solutions was well managed; people we spoke with told us they thought it was. One relative had previously used other care providers, but deemed ICare Solutions to be 'undoubtably the best.'

We asked the staff what they thought of the registered manager and the leadership of the service; they told us, "I think [person's name] is a good manager"; and "I feel supported." One member of staff we spoke with considered the service was a good team. Another indicated that the registered manager was fair and said, "If I raise anything they do listen. [Registered manager] does support us." There was an obvious chain of command and the registered manager and director were hands on in the office.

As part of the inspection we asked the registered manager how the service was audited for safety and quality and how improvements were identified and implemented.

We saw no record of spot checks that had recently been undertaken on employees to ensure competency in the caring role in the files we looked at, although the service had existing documentation in place to record spot checks. We did see formal audits with regards to the medicines administration charts and recording of care notes in communication books. We saw that old paperwork had been collected from people's homes and archived at the office, but the audits undertaken on the quality of the recording and completeness of daily notes were not robust. Audits of communication books were only done when these were completed and brought back to the office for archiving and therefore some entries were months old. This meant that any issues and errors with this documentation were not always identified or had not been addressed within acceptable timescales.

When an accident or incident occurred within the service a report of the incident was logged in the communication book. In the example we saw a member of staff had acted appropriately, having logged this in the communication book. It was not clear however if the office had been notified and there was no formal documentation of the incident at the head office. This had not been identified or followed up at the time of the incident, nor when the completed communication book was audited. The system in place for the reporting and following up on any incidents was ineffective, therefore this meant that the registered manager did not have oversight of all the incidents and accidents that occurred at the service and could not respond with corrective actions if necessary in a timely manner.

Some people we spoke with or relatives did express concerns regarding communication from the main office to care workers and to people using the service. One person said, "Communication is not very good. [There's] no rota and no information from the office." Another told us that contacting the office was difficult and a third said, "communication is not brilliant."

The records we saw identified errors on the MAR charts and in the communication book however it was not clear what had been done to address those errors. We could not be confident that any errors in staff practice had been brought to their attention or what corrective actions, if any, had been taken to prevent the errors

from reoccurring.

At the time of our inspection systems were not fully in place to assess and monitor the quality of the service and therefore some improvements had not been identified. This was a breach of Regulation 17(1)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff meetings were held on a quarterly basis and were well attended. The registered manager told us that staff attendance at meetings was monitored. It was important that staff attended so they were kept up to date with aspects of care, commissioning and company updates. Three meetings were held on the same day so that staff could choose which was the most convenient for them. Staff told us they felt they were able to put their views across to management and we saw examples of this from minutes of meetings.

Other types of meetings included one to one supervision sessions with members of staff and appraisals. Staff told us they felt comfortable raising any personal issues or concerns in these sessions. The manager operated an open culture and was approachable we were told.

The company was keen to grow and progress and had introduced initiatives to benefit care workers and help with staff retention. Mileage payments were made for travel incurred and in hard to reach areas the company offered a slightly increased rate to encourage staff to undertake visits. There was a monthly award of "Carer of the Month" and successful staff were awarded a voucher.

One member of staff we spoke with told us that English was not her first language. They told us that they received additional support and help with translations after meetings. Another member of staff who spoke their language had been assigned to assist them and they were comfortable in asking for support. This showed us that the service valued the staff and took measures to support them.

People told us the feedback they provided was regular and verbal, both to care staff and the registered manager. We saw records at the office relating to feedback provided by people using the service. We saw that customer satisfaction surveys had been done with people in February 2016. These were a combination of surveys posted out to the clients and telephone surveys. In February 2016 one person had identified that the morning call was too early before 8am. The provider had responded by altering the planned call to after this time.

We saw that a later survey had been done in December 2016 and the same people had been contacted for their responses. All the responses had improved from the February survey. For example, one person had judged the overall service to be good in February 2016. In December the same person deemed it to be outstanding. Other results also reflected the fact that people considered the service had improved in areas such as receiving regular care staff, communication with the office and overall service. The service could evidence that it listened to people and acted on feedback to improve the overall quality of care delivered to people.

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 11 HSCA RA Regulations 2014 Need for consent Capacity assessments had not been undertaken and the service was not operating in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not perform spot checks on staff and formal audits of the service were limited. Systems were not in place to fully assess and monitor the quality of the service and therefore improvements had not been identified.