ICare Solutions Manchester Limited

ICare Solutions Lancashire

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 13 and 14 August 2018 and was announced. This was the service first inspection.

ICare Solutions Lancashire is a domiciliary care agency, located in Darwen, Lancashire. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults and those people who are at the end of their life. On the day of our inspection there were four people using the service.

The service was managed by a registered manager. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Safeguarding and whistleblowing policies and procedures were in place and were accessible to staff members. All the staff we spoke with were aware of their responsibilities to report any concerns.

Risk assessments were in place in relation to people's health and well-being, to keep people safe. These were reviewed and updated regularly or when changes occurred. Risks had also been considered in the environment.

Recruitment systems and processes in place were robust. We saw references, identity checks and Disclosure and Barring Service checks were completed before staff were employed. Staff we spoke with told us there was enough staff on duty to meet the needs of people using the service and that the service were still recruiting. On the second day of our inspection we saw the branch manager was interviewing prospective new staff.

If it was part of the package of care, staff supported people with their medicines. The branch manager told us that at the time there was only one person who required support and this was in the form of a prompt. Staff had been trained in administering of medicines.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

We have made a recommendation that the provider considers a robust induction programme for when people commence employment, in particular for those people without any previous experience of working in care.

Whilst we did not observe staff interactions with people, all of the staff we spoke with, including the branch manager, talked about people and their roles with sincerity, compassion and empathy.

Staff members we spoke with understood the importance of maintaining people's privacy and dignity. They spoke of knocking on people's doors, covering people up when providing personal care and ensuring curtains were closed.

We saw people had person centred support plans in place which they had been involved in. These were in-depth and covered many aspects of the person's life. People had signed to confirm they were involved in this process.

We have made a recommendation that the service considers current best practice around end of life, such as enhanced training and care planning.

We looked at how the service managed complaints. The service had a complaints policy and procedure in place, which was accessible to staff and the branch manager confirmed they had not received any complaints.

Whilst we found the registered manager was knowledgeable about the corporate and organisational side of the service, they were not so knowledgeable about the running of the Darwen service. On a number of occasions throughout the inspection they did not know where to find things and had to rely on other people to find the information we requested.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

All the staff we spoke with had undertaken training in safeguarding and knew their responsibilities to report any concerns.

Risks people presented with had been assessed and up to date risk assessments were in place. Risks within the environment had also been considered.

Robust recruitment systems and processes were in place.

Is the service effective?

Good

The service was effective.

Staff had received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). All the people using the service had capacity and no one was being restricted.

Staff told us, and records we looked at confirmed that regular supervisions were held with staff. Appraisals had not been held as no one in the service had worked for 12 months.

Whilst training was available and had been completed for staff, we found a lack of end of life training available. We discussed this with the registered manager who assured us this would be actioned.

Is the service caring?

Good

The service was caring.

One relative we spoke with was very complimentary about the staff and the service they had received. They told us how they felt the staff had become part of the family.

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

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

Is the service responsive?

Good

The service was responsive.

We saw people had person centred support plans in place which they had been involved in. These were in-depth and covered many aspects of the person's life.

There was a complaints policy and procedure in place within the service. Staff were aware of this and knew how to respond should someone make a complaint.

We saw technology was used in the service to support people. Some people had a 'key safe' so that staff could access their homes.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

A registered manager was in post but did not have a consistent oversight of the branch, spending most of their time in another office. There was a branch manager in place who staff felt very supported by.

Staff meetings had been held in 2017 and we saw evidence of this. The branch manager assured us that a staff meeting had been held in 2018 but this could not be evidenced during the inspection.

Policies and procedures were in place and accessible to guide staff in their roles. These had been reviewed and updated as required.

ICare Solutions Lancashire

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 13 and 14 August 2018 and was announced. This inspection was conducted by one adult social care inspector. This was the first inspection for this service.

We gave the service 48 hours' notice of the inspection visit because it is a domiciliary care agency and the registered manager and branch manager are often out of the office supporting staff or providing care. We needed to be sure that they would be in.

In preparation for the inspection, we reviewed the information we held about the service such as notifications, complaints and safeguarding information. We obtained the views of the local authority safeguarding and contract monitoring team and local commissioning teams. We also contacted Healthwatch to see if they had any feedback. 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 asked to submit a Provider Information Return. This is information we ask providers to send us to give some key information about the service, what the service does well and improvements they plan to make. However, due to a change in registered manager it was not possible to ascertain if this had been completed or not. Our records showed we had not received this.

We reviewed a range of records about people's care and the way the service was managed. These included the care records for three people, medicine administration records, staff training records, four staff recruitment files, staff supervision and appraisal records, minutes from meetings and records relating to the management of the service.

We also spoke with the registered manager, branch manager and two care staff. After discussions with the registered manager and branch manager it was agreed it was not suitable to visit people in their own

homes. Therefore, on the 16 August 2018 we made phone calls to one person who used the service [who we could not manage to speak with] and one relative to get their feedback.

Good

Is the service safe?

Our findings

Staff we spoke with confirmed they had received training in safeguarding. One staff member told us, "If there is anything we think is not right we just phone the office. Luckily I have never had to but we do have to be aware of safeguarding all the time." Both staff members told us they felt able to whistle blow [report poor practice].

We asked the registered manager how they ensured people who used the service were safeguarded. They told us, "We have training for the staff so they are aware of the signs of abuse and what to look out for. In the statement of purpose we mention whistleblowing and the 'No Secrets' policy and we try and capture information from surveys. We are trying to get away from family members being the source of notification and looking at alternative ways of giving staff the ability to raise concerns."

Safeguarding and whistleblowing policies and procedures were in place and were accessible to staff. Training records we looked at also confirmed safeguarding training was undertaken.

We looked at what consideration the registered manager had made about risks that people presented with or risks in the environment. The registered manager told us, "The initial risk assessment starts at the beginning of any package. If there are any changes to the care or the environment it will drive a change in the risk assessment. Other than that they are reviewed every six months."

We found risk assessments were in place in all the care records we looked at. For example, one person had a moving and handling risk assessment in place which showed a hoist was required when moving. We also saw risks in the environment had been considered, such as, appliances, any equipment in the persons home and control of substances hazardous to health (COSHH). Risk assessments had been completed to keep people safe.

Staff we spoke with told us they had received training in moving and handling. They told us, "We had a manual handling training session here in the office" and "I did moving and handling training when I started. It was a small group and we practised using a hoist and slide sheets. We knew how to move people safely for both us and the patient."

Records we looked at showed that one person had a hoist in place within their home for staff to manoeuvre them with. Within the support plan it documented the make and model of the hoist, when it was serviced and by whom. This ensured staff knew equipment was safe to use.

We noted there was an accident and incident policy in place, which detailed how accidents and incidents should be managed. There was an accident book in place, although this was blank as the branch manager confirmed there had been no accidents to report since the service commenced.

We asked the registered manager how they ensured robust recruitment processes were in place. They told us, "We work with our policy for recruitment. We look at people's motivation to do the job. We ask people a

lot of questions during the interview to explore the reasons why people want to work in care. We capture all a person's identification during the face to face interview stage."

We looked at the systems in place to ensure staff were safely recruited. The service had a recruitment policy in place to guide the manager on safe recruitment processes. We reviewed three staff personnel files. We saw that all of the files contained an application form and two references. Any gaps in employment had been checked by the registered manager. Checks had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. Prospective staff were interviewed and when all documentation had been reviewed, a decision taken to employ the person or not. This meant staff had been suitably checked and should be safe to work with vulnerable adults.

All the staff we spoke with, told us that staffing levels were correct for the amount of people using the service. One person told us, "Sometimes we end up working a long day but we all 'muck in'. There is enough staff and [branch manager] is also recruiting." We looked at the electronic rosters which showed there were enough staff employed to meet the needs of people using the service. The branch manager told us they were recruiting at the time of the inspection as they wanted to increase the packages they could offer. We observed an interview took place on the second day of our inspection.

We looked at how the service supported people with their medicines. The level of assistance each person needed was recorded in their care plan along with guidance on the management of any risks. There was only one person using the service that required assistance from staff at the time of our inspection. All staff had completed appropriate medicines training and had access to a set of policies and procedures. There were suitable records in place to record the administration of medicines as the service had recently updated their medicine administration record (MAR) to contain more detail.

All the staff we spoke with, told us they had received training and were aware of their responsibilities in relation to infection control. One person told us, "It is our responsibility to do everything we can to prevent infection. We use personal protective equipment (PPE), wash hands before and after doing anything." Staff told us they had access to PPE and it was always available to them.

We asked the registered manager how they ensured staff understood their responsibilities to raise concerns and report incidents. They told us, "It is not just staff responsibility it is also about their own accountability to raise things. We are trying to raise a culture where we review lessons learned, having regular contact with staff and we are looking at alternative ways of staff being able to raise concerns. We cover this in induction, staff meetings and supervisions."

We also asked the registered manger how they shared lessons learned with staff. They told us, "At managers meetings we ask for good and bad news stories; we will share this amongst everyone. We are currently thinking of doing a newsletter. We want to make sure these things are shared and staff don't just keep things to themselves."

Good

Is the service effective?

Our findings

One relative we spoke with told us, "The quality of care delivered has been amazing. Top class."

We asked the registered manager how they ensured staff had the right skills, knowledge and experience to do the role. They told us, "It is captured at interview stage; their motivation to do the job. You can send someone on a course to move and handle but you cannot send someone on an empathy course. So it is about making sure they have that during the interview stage. We do between 12 and 18 hours shadowing and if people are not comfortable they will go back through induction. We have people who have done it twice. Also, if something is identified at spot checks, it may be that they need further training."

All the staff we spoke with and records we looked at, confirmed they had an induction when commencing employment. One staff member we spoke with told us, "I had training in the office and had forms to fill out. I went on quite a few shadowing visits with the manager at the time so I was introduced to the clients and their routines. I was asked if I felt safe to go out on my own and I am sure if I was not then the shadowing would have continued." The induction was a one day session which included training in areas such as, safeguarding, medicines, moving and handling, infection control and fire safety. Staff were then paired with a more experienced staff member to work alongside until such time as they felt confident to work alone.

For those people who were employed without previous experience of working in the health and social care sector, they were not expected to complete the Care Certificate. The Care Certificate is an identified set of best practice standards that health and social care workers adhere to in their daily working life. We recommend the provider considers a robust induction programme for when people commence employment, in particular for those people without any previous experience of working in care.

We asked one staff member what training they had completed since they commenced employment. They told us, "I have done safeguarding, medication, infection control, manual handling, dignity, equality and diversity; I have done loads." We looked at the training matrix to see what other training was available to staff. We saw people had completed dementia awareness, equality and diversity and Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The service took on packages of care when people were at the end of their life. However, end of life training was not available for staff. We discussed this with the registered manager who assured us that this would be looked at.

We asked staff if they received regular supervisions. One staff member told us, "I haven't had one for a bit but yes we do have them regularly. There has been a lot of change recently. I must be due one." Records we looked at showed staff had regular supervision sessions. This was done either on a face to face basis when possible or via telephone due to being a dispersed workforce. The service was relatively new and as such none of the staff had been in employment long enough to have an appraisal.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible

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

Training records we looked at showed staff had undertaken training in MCA and DoLS. We asked one staff member what MCA and DoLS meant to them. They told us, "That everyone has rights and everyone should be treated with dignity and respect. You cannot assume someone has not got capacity, you have to assume they have until it is proven that they haven't. You have to give people choices."

All of the people using the service at the time of the inspection had capacity to consent to their care and treatment; no one was being restricted. We saw support plans that were in place had been signed by the person to consent to their care arrangements. People had also signed agreement to show the information contained in their records was correct and that they had been involved.

We asked the registered manager who they worked together with external bodies when a person was being transferred to them or leaving the service. They told us, "We have a lot of handovers with the re-ablement team etc. When someone comes out of hospital, depending on their complexity, we may do a three, four or five day handover period. We once had staff working with an agency for a week before taking over. We are big on cross agency working and embracing it on a client led basis."

Good

Is the service caring?

Our findings

One relative we spoke with was very complimentary about the service. They told us, "The staff have been amazing, we could not have asked for any better care. They have made us feel so comfortable and have been like part of the family. I honestly cannot thank them enough."

Due to people being on holiday or unwell, we were unable to visit people in their own homes, so we did not observe staff interactions with people. However, all of the staff we spoke with, including the branch manager, talked about people and their roles with sincerity, compassion and empathy. We asked staff how well they knew people they were caring for. One staff told us, "Very well, as we have been told by a lot of family members – we have become part of their family as we are a small team." Staff also told us they knew what people liked and what the person wanted staff to do for them during their visit.

All the staff we spoke with were aware of the Equality Act. We asked them what this Act meant to them in practice; one staff told us, "That everyone has to be treated according to their race, religion, gender etc. You cannot single anyone out." Another staff told us, "Regardless of someone's gender, sex, race or sexuality everyone has the same opportunities."

We looked at how the service promoted equality and diversity. Equality is about championing the human rights of individuals or groups of individuals, by embracing their specific protected characteristics and diversity relates to accepting, respecting and valuing people's individual differences. In a discussion about equality and diversity, the registered manager told us, "Care plans are the key document when supporting someone with protected characteristics. We would ensure training for staff and supervisions were tailored before any care commenced. Our policies and procedures cover the protected characteristics under the Equality Act and these are accessible to staff." Training records we looked at showed that staff had undertaken training in equality and diversity.

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

We looked at how people's privacy and dignity were being respected. We asked staff how they ensured people's privacy and dignity was respected when they were supporting them. One staff told us, "I make sure the curtains and windows are closed. If there is anyone else in the house I make sure the doors are closed and keep them covered up as much as possible. For example, if I am washing someone's top half I will cover their bottom half and vice versa. If I am supporting them to the bathroom I will make sure they have a dressing gown on. Some people have a 'key safe' so we can let ourselves in, but I would always knock on the door, open it and introduce myself." Another staff told us, "I would close the curtains and doors. If they were doing their own personal care I would look away, if I was supporting them I would cover them with a towel as much as possible."

One staff member we spoke with had achieved their dignity champion certificate. This showed the person had attended enhanced training in this area and would be able to support other staff.

Staff were aware of the importance of maintaining and building people's independence as part of their role. Both staff, throughout discussions with them spoke about allowing people to do things for themselves. One staff told us, "I prompt them to do as much as they can by themselves and support them when required." Care records we looked at detailed the level of care and support a person needed.

Personal records, other than those available in people's homes, were stored securely in the registered office. Staff files and other records were securely locked in cabinets within the offices to ensure that they were only accessible to those authorised to view them.

All the staff members we spoke with confirmed they would be happy for one of their relatives to use the service.

Good

Is the service responsive?

Our findings

We saw people had person centred support plans in place which they had been involved in developing. These were in-depth and covered many aspects of the person's life, such as, mobility, personal care needs, days and times of visits from staff, any medical conditions including allergies, communication needs and spiritual needs. Support plans were detailed and directive for staff, for example, one person's support plan showed they wanted staff members to knock on the door, shout hello and enter the house.

Included in people's support plans, was an 'what you need to know about me' sheet. These contained information such as a brief history of the person's health, their likes and dislikes, family background and personal history. These gave staff a clear picture of the person and things important to them.

We saw daily notes in people's care records were clear and legible. These were detailed and showed what support the staff member had given during their visit to the person.

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

The registered manager told us that most of the referrals they received were from hospitals or hospices, when people were being 'fast tracked' at the end of their life for them to be cared for in their own homes. Support plans we looked at, whilst containing lots of information about supporting people with personal care and medical conditions, were not focussed on end of life care [where necessary]. We spoke with the registered manager and deputy manager in relation to this. They told us, in the main family members dealt with the end of life wishes of the person. However, support plans should be detailed enough to show that this had been considered. Staff members had not received robust training in end of life care; end of life training was covered at a basic level during induction. We recommend the service considers current best practice guidance and training when supporting people at the end of their life.

We looked at how the service managed complaints. We asked staff what they would do if someone wanted to make a complaint. One person told us, "I would listen to them first of all and try and not put words in their mouth. I would then bring it all back to the office, fill a form out and [name of branch manager] would investigate it. There is a procedure we have to follow." The service had a complaints policy and procedure in place, which was accessible to staff and the branch manager confirmed they had not received any complaints.

We checked if the provider was following the Accessible Information Standard. The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can

access and understand, and any communication support that they need.

We asked the registered manager how they were meeting the requirements of this standard. They told us, "We have access to a company that will put our care plans into braille, we have flash cards and we can print things in larger fonts." It had not been necessary for the service to make any adjustments up to the time of our inspection but the registered manager knew where and what they could access.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager was also registered at two other branches of the company, based in Manchester, where they spent most of their time. They told us they spent one day a fortnight at the Darwen branch. Whilst we found they were knowledgeable about the corporate and organisational side of the service, they were not so knowledgeable about the running of the Darwen service. On a number of occasions throughout the inspection they did not know where to find things and had to rely on other people to find the information we requested. We discussed this with the registered manager and they agreed that they would spend some more of their time at the Darwen site to support the branch manager. They also told us the intention was for the branch manager to apply for the registered manager's position in the not too distant future. We found the branch manager very knowledgeable about the Darwen branch.

All the staff we spoke with felt well supported by the branch manager. They confirmed that the registered manager did attend the service occasionally. Staff told us the branch manager was very approachable commenting, "She will bend over backwards to make sure you can go on any appointments." All the staff felt they were supportive of each other in their roles. We also asked how well the registered manager communicated with them. All the staff felt communication came from the branch manager and told us, "She communicates very well. You will get texts saying thank you for today. It makes me feel valued and appreciated."

In preparation for the inspection, we checked the records we held about the service. We found that the interim manager had notified CQC of any accidents, serious incidents and safeguarding allegations as they are required to do. This meant we were able to see if appropriate action had been taken to ensure people were kept safe. However, we had not received the Provider Information Return which we had asked to be completed. The current registered manager could not ascertain if this had been completed by the previous registered manager or not, however our records showed we had not received it.

We asked the registered manager how they kept up to date with changes in regulations and legal requirements. They told us, "Research. I am signed up to the update service and the local authority are good at informing us when there is a change. There are workshops which I go to and we review our policies every year. We also work with Skills for Care and we get a lot of information from them. I also attend provider/manager forums."

We asked staff members if they had regular staff meetings. One staff told us, "We do have them but we must be due one." Records we looked at, showed staff meetings had been held in October 2017 and December 2017. The branch manager was certain a further staff meeting had been held this year but was unable to provide the evidence of this. Staff meetings are an opportunity to keep staff up to date with organisational

information, service user information and provide a good opportunity for feedback.

We looked to see if surveys were sent out to people who used the service, their relatives and staff members. The branch manager showed us some completed surveys they had received back from people who used the service. However, these were not dated [to show they were recent] and the results of these had not been analysed. The registered manager showed us how they collated the information from surveys at the other branches, however it was discussed that this should be occurring at the Darwen branch also.

Staff we spoke with told us they were not given surveys to complete.

We asked the registered manager how they ensured quality was an integral part of the service. They told us, "We send out feedback surveys, talk to clients, when the new monitoring system comes out that will tell us lots of information. It's about getting staff to speak to you, they are the ones with the knowledge if anything needs to change."

We looked at what systems and processes the registered manager had in place to monitor and improve the quality of the service. We saw an organisational wide audit tool was used to monitor policies, procedures, systems and processes. If there were any changes or updates, these were sent through to all the branches. Within the Darwen branch, quality monitoring spot checks were also undertaken twice a year for each person using the service. These audited care plans, medicines records, food diaries, body maps, risk assessments, infection control and the complaints process. They also allowed for people using the service to give their feedback.

In regards to improvements, we asked the registered manager how they drove this. They told us, "I never sit still. I review, amend and update. I embrace technology and ideas from people. I keep trying to improve and move forward."

Policies and procedures were in place and accessible to guide staff in their roles. These had been reviewed and updated as required.

We asked the registered manager what they felt had been key challenges for the service. They told us, "We have good staff, experienced staff but they do not have enough access to work. It feels like we are scrambling around for work." We also asked what they felt had been key achievements for the service. They told us, "We have very consistent rotas; that being said we are also able to move things around if we need to. When we introduce the mobile network solutions it will make a big difference to staff."