Care Solutions Recruitment Agency Ltd

Care Solutions Recruitment Agency Ltd - Manchester

Inspection report

Unit 207, Piccadilly House
49 Piccadilly
Manchester
M1 2AP

Date of inspection visit:
14 March 2023

Date of publication:
08 September 2023

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Care Solutions Recruitment Agency Ltd – Manchester is a domiciliary care agency providing care predominately to children in the community or their own homes. The service supports children with various physical needs as well as autistic children and children with a learning disability. At the time of the inspection the service was supporting 4 children out of the 11 they supported with personal care.

People's experience of using this service and what we found
Right Support:
Risks in relation to moving and handling, medicines, infection prevention and control and complex care had not been explored. Risk assessments were often not completed, which meant there was no guidance for staff about how to support people safely in these areas.

Right Care:
The service did not have enough suitably trained and skilled staff to meet people's needs and keep people safe. Staff received training on safeguarding adults and abuse awareness, but no additional training was provided on safeguarding children, this was concerning given the service predominantly supported children.

Care was not always person centred and co-ordinated well. Information in the children's care plans did not reflect their full range of needs or promote their well-being and enjoyment of life. Guidance for staff was sometimes missing and did not therefore enable personalised and accurate support.

Right Culture:
There was not always a person-centred culture at the service. Systems and processes had not been followed for quality assurance and to improve the service people received. The registered manager did not have oversight of the service and did not conduct any audits and analysis of quality themselves. This meant the quality-of-care people received was not sufficiently monitored and areas of concern not always identified.

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

Rating at last inspection
This service was registered with us on 19 April 2022, and this is the first inspection.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

Enforcement and Recommendations
We have identified breaches in relation to medicines, managing risks, safe care, unsafe recruitment, staff training, and quality assurance processes at this inspection.

We have made a recommendation about the service approach to the Mental Capacity Act (MCA).

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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Care Solutions Recruitment Agency Ltd - Manchester

Detailed findings

Background to this inspection

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

Inspection team
This inspection was carried out by 2 inspectors and 1 medicines inspector. The medicines inspector supported this inspection remotely.

Service and service type
This service is a domiciliary care agency. It provides personal care to children living in their own houses and flats.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

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

Notice of inspection
This inspection was unannounced.

Inspection activity started on 14 March 2023 and ended on 21 March 2023. We visited the location's office on

14 March 2023. We held a meeting with the registered manager and branch manager via remote technology on 23 March 2023.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. Following our inspection, we sought feedback from the local authority and professionals who work with the service.

We used information gathered as part of monitoring activity that took place on 6 March 2023 to help plan the inspection and inform our judgements.

During the inspection
Due to the needs of the children they were unable to talk to us. We therefore spoke with 5 of the children's relatives. We spoke with the branch manager and 5 staff. We also received 2 responses from staff following our email questionnaires we sent out to all staff.

We reviewed 4 children's care records and associated information. We reviewed 7 staff recruitment and induction records and a variety of other admin documents and policies.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection of this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely

- People's individual risks had not been assessed in detail and the safe administration of medicines was ineffective for 1 person.
- People had not had risks assessed sufficiently for areas such as medicines, moving and handling, accessing the community and managing long term conditions. For example, 1 person had a Percutaneous Endoscopic Gastrostomy (PEG) in situ, we found no risk assessment or care plan had been created. This was concerning given the fact staff provided support 4 times a day to this person with feeds and administration of medicines via their PEG.
- A second person's external assessment indicated they were vulnerable when accessing the community and had no comprehension of danger. We found no risk assessment had been undertaken by the provider and on 1 occasion we found there had been a near miss incident in the community. We raised a safeguarding alert with the local authority, as this matter had not been reported.
- At the time of inspection, the service supported 1 person with medication administration. We were not assured this person's medicines were managed safely. No medicines administration records were completed to monitor whether this person's medicines had been given safely.
- During the inspection we received contradictory information from the registered manager that the service did not support people with medicines. However, when we spoke to the branch manager, they informed us support with medicine administration was provided to 1 person and this had been the case for several months.
- We requested this person's medication administration records on 2 occasions; however, these were not provided. We were not assured this person's medicines were being managed safely and in line with best practice. Furthermore, staff had not received training in medicines administration. This placed people at risk of harm because they were given medicines by staff members who did not understand the risks.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. Medicines were not managed or monitored safely and required assessments and protocols not in place. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- The provider failed to ensure they were employing staff who had the right skills to do the role.
- Pre-employment checks such as disclosure and barring checks were inconsistent, and records showed numerous discrepancies in all staff files we viewed. For example, we found the service failed to complete a new Disclosure and Barring Service (DBS) check or complete the DBS update check for 5 staff. These checks provide information including details about convictions and cautions held on the Police National Computer.

The information helps employers make safer recruitment decisions. This meant the service could not be assured the staff members DBS was clear.
● Staff references had not all been verified or explored where there were discrepancies. Gaps in staff employment had not been explored and recorded.
● Recruitment procedures were not effective in assuring the provider of the staff members good character and conduct necessary for them to safely perform their role.

The provider had not ensured recruitment systems were operated effectively to ensure staff were fit and proper to carry out their role. This placed people at risk of harm. This was a breach of regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staffing levels and rota systems were unsafe. The provider did not have a clear system in place that detailed the times staff needed to provide support to people. A rota of just dates were provided to staff. One staff member told us, "I tend to get a call from the manager the day before to see if I can pick up some hours, I don't have a rota."
● People's relatives gave mixed views on staffing levels and the reliability and punctuality of the service provided.
● Feedback from some people's relatives included, "The carers that were coming were lovely and young, but really unreliable and not fair for to [person's name]. We had had many carers come and go, when it got to 3 weeks with no one turning up I said something. A bit of a nightmare" and "It has taken time to have some stability with the staff, but they are often short staffed."
● The branch manager told us they were looking to introduce new technology to monitor arrival and departure times to improve overall time keeping. At the time of inspection there were no systems for the provider to review the frequency and timeliness of calls.

The provider had failed to deploy sufficient numbers of staff to make sure they could meet people's needs. This placed people at risk of harm. This placed people at risk of harm. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were not safeguarded from the risk of abuse, particularly neglect due to late, early, short and missed calls.
● We made 2 safeguarding referrals to the local authority regarding a concern for people's safety during the inspection.
● Staff told us they had received safeguarding training and records we saw confirmed this. However, given the service predominantly supported children, enhanced children's safeguarding training for staff had not been provided.

Learning lessons when things go wrong
● The branch manager explained the service had an incident tracker if they needed to record accidents or incidents, but stated the service had not needed to use it yet. However, we were not assured incidents were being recorded or reported correctly. During a review of 1 person's daily notes, we identified a potential near miss incident while the person accessed the community, this had not been reported formally at the service in order to learn and reduce risk.

Preventing and controlling infection
● The provider ensured there was enough personal protective equipment (PPE) available for people and staff.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Staff training and induction was ineffective. The training programme set out meant staff had to cover 11 subjects within 1 day. This did not give sufficient time to support staff, to learn and understand how to perform their role safely and effectively. This was evident when speaking with staff, some staff told us they could not remember if they had training or not in some subjects.
- People's relatives did not feel that all staff were trained well or competent in their roles. One person's relative said, "Some staff are not prepared when they care for [person's name], at times I have had to intervene due to staff completing moving and handling incorrectly."
- We were not assured staff were suitably and sufficiently trained to meet the needs of people. The branch manager provided us with additional training certificates for some staff members; however, we were not assured the trainer/tutor who completed this training held the appropriate certification to deliver this.
- Staff did not have a good understanding of the conditions people were diagnosed with and how best to support them. Staff did not understand how to support autistic people. In July 2022, The Health and Care Act 2022 introduced a requirement that where providers support people with a learning disability and autistic people staff must receive training that is appropriate to their role. The majority of people the service supported were autistic people, however no formal training had been provided to staff.
- Staff had not completed the Care Certificate. where necessary. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
- All of the staff we spoke with told us they felt supported by the branch manager, but we found no formal supervisions were completed. For example, the branch manager stated they would provide support to staff but did not always write these conversations down. There was also no evidence of competency assessments.

The provider had not ensured staff were supported to have the right skills, knowledge and understanding to perform their roles. This placed people at risk of harm. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- The registered manager and branch manager had not ensured that people's needs were assessed and recorded prior to providing care. In some people's care records there was only evidence of the local authority care needs assessment. The information from the local authority had been used to develop their care plan.

● People and their relatives were not always involved in the assessment of needs and preferences in how their care was delivered. People's relatives told us they had a chat with the provider about the care at the start, but there was no evidence of what had been discussed, if risks to the person had been explored or what their current care needs were.
● People's initial assessments were not always completed. Initial assessments help inform people's care plans to ensure their needs can be met. For example, 1 person had a long-term health condition that the service provided support with. However, we found no risk assessment or care plan in place to ensure practical clear guidelines were in place for staff.

The provider did not do all that was reasonably practicable to mitigate risks to people. This placed people at risk of receiving unsafe care. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

● Staff did not understand the principles of the MCA or recognise restrictive practices. Staff had not been provided with training on the MCA.
● The branch manager explained where possible the people they supported were encouraged to make all decisions for themselves. However, we found there was lack of understanding around the MCA particularly around the legislation for children. The providers MCA policy and procedure was ineffective and made no reference to the Gillick competency. The Gillick competence is used in medical law to establish whether a child (16 years or younger) is able to consent to his or her own medical treatment without the need for parental permission or knowledge.

We recommend the provider follows current legislation and best practice on the MCA and reviews their policies and procedures.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People were not supported in line with their nutritional needs. One person's relative explained they had to intervene at times due to the feed being prepared for Percutaneous Endoscopic Gastrostomy (PEG), not being suitable. We found staff had not received training in PEG and this placed the person at risk of unsafe care.
● The service was not commissioned to provide support with health appointments. We have therefore not

been able to review this key line of enquiry.

● The branch manager told us they were building positive relationships with social workers and felt this would support joined up care.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- Feedback from people's relatives about how well their family member was supported was mixed. Some people's relatives felt most staff were friendly and caring, but some staff lacked the communication skills to provide consistent support. For example, 1 person's relative told us, "Some staff don't seem to have an understanding of autism, I have noticed some struggle to understand [person's name] needs."
- People's care plans lacked information to help staff get to know people well, including people's preferences, personal histories and backgrounds.
- Staff we spoke with understood the importance of treating people with kindness and respect. A member of staff told us, "I love the children I care for; I do my best for them."

Supporting people to express their views and be involved in making decisions about their care

- People were not supported to be involved in decisions about their care. Care records did not contain any detail about people's cultural or religious needs.
- People's relatives told us the provider would often ask for feedback on the service in the way of a survey, however there no formal care plan reviews in place for relatives. A relative told us, "I do speak to the manager often, but this is the air my frustrations. A face-to-face review would be helpful, but this hasn't happened."

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was respected. Relatives told us that people's privacy and dignity was maintained by staff ensuring that they closed doors and curtains when supporting them. 1 staff member explained in detail how they have in the past protected a person's dignity while out in the community, this was done in a caring and sensitive manor.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This was the first inspection of the service and rated as requires improvement. This meant people did not feel well-supported, cared for or treated with dignity and respect.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's care was not always personalised. Care plans were often provided minimal information. This meant guidance for staff was not always clear about how to support people's preferences.
- For example, care plans stated people had certain health conditions, but there was no information about these or how staff should monitor or support them with these. Some people had complex care packages, which meant there was a level of risk when accessing the community. There was not enough information about their needs or how they should be supported.
- The staff we spoke with explained they did their best to get to know people. One staff member expressed some previous challenges they had when working with a new person due to not knowing very much about them, but after time they got to know this person in order to provide person centred care. This was a further indication that the lack of person-centred care planning was exposing people and staff to unsafe care.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- We found some people at the service had specific communication needs. For example, 1 person required a communication board with symbols in order to communicate, however this person's relative told us staff did not consistently follow this method of communication.
- People were not always supported with their communication needs. Some people did not use words to communicate. The staff had not been trained to understand how to communicate effectively and people's care plans did not give enough information about how they communicated. Therefore, they were not always heard or understood by staff.

The provider failed to ensure sufficient guidance for staff to ensure people's care needs could be met in away that reflected their preferences and respected choice. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

- At the time of our inspection, no person was in receipt of end-of-life care.

Improving care quality in response to complaints or concerns

● There was a complaints policy and procedure in place. Most people knew how to complain and would do so if required.

● The provider did not have robust systems in place to manage complaints effectively. Complaints were not recorded. Relatives told us during our inspection that they had raised some low-level concerns and complaints. These were not recorded in the service's complaints logs. This meant we could not be assured that complaints were recorded, investigated and actions arising from complaints were implemented.

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.

This is the first inspection for this newly registered service. This key question has been rated 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

- There were widespread shortfalls in the day to day running of the service, leading to multiple breaches of regulation. There was a lack of oversight by the registered manager and provider.
- We found the registered manager had little oversight of the day to day running of the service and worked at the providers other location based in Croydon and had not visited the service in over 2 months. There was an over-reliance on the branch manager to run the service.
- Governance processes were ineffective. There was no quality assurance framework in place that would enable the provider to measure the quality of care. No audits were completed at the service.
- During the inspection we found the service was not prepared for an inspection. It took 4 hours for the branch manager to make themselves available for this inspection. When we were on-site some records such as people's daily notes were not available, as the branch manager was unable to locate these.
- During the inspection we requested assurances regarding training staff should have received for 1 person. The branch managed assured us this training had been provided to all staff. After further inquiries with hospital health professionals, we were informed no formal training had been provided. This was a further indication the service could not meet people's needs.
- The provider's approach towards staff rotas and call scheduling meant people's care needs would not be safely and effectively met. A poor culture had developed at the service, where new staff were not trained and planning people's scheduled visits was sometimes done on a day-to-day basis.
- The provider did not keep up with best guidance to inform improvements to the service. Staff were not supported with regard to their professional development and supported to reflect on their practice.

Systems were either not in place or not robust enough to demonstrate quality was being monitored and assessed. Staff competence was not being effectively monitored and managed. This placed people at risk of harm. This was a breach of regulation 17(1) 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

- Improvements were needed to ensure people received empowering, high-quality care and good outcomes. The provider had failed to develop a positive, person-centred culture.
- Safe recruitment checks of staff were not followed, and staff did not receive appropriate training.
- People's relatives provided us with a mixed view regarding how well-led the service was. For example,

comments included, "[Branch manager's name] does his best, but it's always the same old excuses when he tells me staff are running late" and "I am not aware they had a registered manager, I have always dealt with [branch manager's name], this concerns me."

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

● Relatives were given opportunities to share their feedback. For example, the provider completed surveys. A relative we spoke with informed us they were often asked to complete these surveys, but didn't always feel confident stating how they felt, due to the surveys not being anonymised.

●The branch manager explained they had held regular staff meetings; however, there were no records to show these meeting had taking place.

● The staff we spoke with felt supported by the branch manager. A staff member told us, "The service is much better now, we have recruited new staff which has been a blessing. [Branch manager's name] is doing a great job."

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;

●The registered manager and nominated individual lacked awareness of their statutory responsibilities in relation to safeguarding and statutory notifications to inform CQC of certain changes, such as informing CQC in a timely manner they were no longer dormant. It took the service 5 months to inform CQC they had started to provide support to people. These matters will be followed up outside of the inspection process.

● Systems and processes were not in place, so we could not be sure they would identify when things had gone wrong and be able to respond accordingly.

Working in partnership with others

● There was some evidence of working with the local authorities, for example taking on emergency packages of support. Following this inspection, we held urgent meetings with the children commissioning teams' representatives for Manchester and Salford, to share our findings of this inspection.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure sufficient guidance for staff to ensure people's care needs could be met in away that reflected their preferences and respected choice.

The enforcement action we took:

Cancellation of registration

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. Medicines were not managed or monitored safely and required assessments and protocols not in place. This placed people at risk of harm.

The enforcement action we took:

Cancellation of registration

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were either not in place or not robust enough to demonstrate quality was being monitored and assessed. Staff competence was not being effectively monitored and managed. This placed people at risk of harm.

The enforcement action we took:

Cancellation of registration

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

	The provider had not ensured recruitment systems were operated effectively to ensure staff were fit and proper to carry out their role. This placed people at risk of harm.

The enforcement action we took:

Cancellation of registration

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured staff were supported to have the right skills, knowledge and understanding to perform their roles.

The enforcement action we took:

Cancellation of registration