Monitoring Summary Record

Intercare Services Direct Limited

1-5716151711

Location / Core Service address

Intercare Services Direct Ltd
S O A R Works
Knutton Road
Sheffield
S5 9NU

CQC continues to develop its approach to monitoring with a focus on safety, access and leadership.

We have reviewed the information and data made available to us about your service on 12/04/2022.

We consider that no further regulatory activity is indicated at this time. We reserve the right to keep this under review and it may be subject to change. Please note this is not an assessment for the purposes of section 46 of the Health and Social Care Act 2008.

This monitoring activity is part of our Monitoring Approach 21/22 and is not an inspection. Monitoring summary records are not inspection reports and are not published on our website. They are an account of our monitoring activity. We do not expect them to be shared publicly to give assurance on the quality of care you deliver.

This summary record outlines what we found as a result of our monitoring activity:

We undertook a direct monitoring approach call with the registered manager and one of the quality assurance officers on 12 April 2022.

The CQC will continue to monitor this service and no further regulatory activity will be initiated at this time.

We discussed and were shown evidence of improvements which had taken place since the last focused inspection in December 2020.

You told us people's care plans were on the electronic care planning system and the

use of a paper copy was no longer in use. You said all care plans were reviewed following the last inspection to ensure all information was accurate and up to date.

You told us people and families had access to the system to enable them to keep up to date with care delivery.

You said new monitoring systems had been introduced in the form of a dashboard and we saw a copy of this. You told us this enabled you to be proactive to manage incidents and accidents and to identify errors, for example medication. You provided us with an example of positive outcomes for people.

You told us the electronic recording system sent an alert to the office if a care call was late, not taken place or specific tasks had not been completed. You told us actions were taken to make sure the delivery of care was maintained.

We saw care plans for people which had identified individual risks, clear instructions for staff to follow and how to manage the support the person required.

You told us body maps were used for people where medication provision was needed to be recorded, for example, pain patches and topical creams. You said these were not on the system, but a paper copy was held in the person's home.

You said updates to people's care was recorded in people's care plans, including changes to risks. You told us staff were sent a text to alert or a link to your website to inform them of changes in care needs.

You told us moving and handling equipment was checked by staff before use, this included slings to assist people being moved safely.

You told us following recent incidents improvement had been made to maintain people's safety. You provided us with examples of improvements made.

You said continuity of care for people had been affected during the pandemic. You told us this had now improved and comments we received supported this.

You told us there were enough staff to look after people safely. You said you had to make the decision to return some care packages to the commissioner due to staff shortage. You told us this ensured people received a safe and quality service.

You told us PRN protocols were in each person's care plan. We saw examples of this including clear instructions for staff to follow when administering PRN medication and the impact of this medication.

You said controlled were not administered to any client. You said staff were checked annually to ensure they were competent to administer medication. You said, if any errors occurred, staff would be checked following an incident and would not be able to administer medication until you were satisfied they were safe to do so.
You said care plans were reviewed every six months. But if any changes occurred before, including risks, care plans would be updated immediately.

You told us you had governance processes in place to monitor quality and to make improvements to care needs. You said quality assurance officers undertook regular audits and fed the results into the main audit plan. We saw care plan audit results for January, February and March 2022. You told us these details were then shared at board level and any anomalies were investigated, lessons learnt exercise undertaken and improvements were put in place. You said a senior management team meeting took place on a fortnightly basis and we saw copies of minutes to support this.

You said audits were carried out on paperwork held in people's homes. These were the body maps and medication administration records. You told us and we saw a sample of 10% was checked on a monthly basis.

You said and we saw you had updated your business continuity plan to include actions to be taken if staff were unable to update the electronic care plan system.

You told us and we saw evidence that people were regularly asked for feedback about the service. You said a full analysis of comments was done and changes were made to make improvements. You said people and families received regular updates of actions via a newsletter which included the section, 'You said, we did'. We saw a copy of a recent newsletter.

We received positive and negative feedback about the service and you told us how you had addressed some of the concerns raised.