Rings Homecare Service Ltd

Greater Manchester

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Greater Manchester, known by people using the service as Rings Homecare, is a domiciliary care service based in Bolton, Greater Manchester. The service is registered to provide care and support to children, younger and older adults living in their own homes, although the service was currently not supporting any children.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. At the time of inspection, 55 people used the service, however, only 40 of these received personal care and were included in the inspection.

People's experience of using this service and what we found
We found improvements were required with person centred care, linked to the timing of people's care visits, medicines management and the audit and governance process.

We received mixed feedback about the timeliness of care visits, and documentation showed visits were sometimes later than scheduled. Medicines were not being managed safely, record keeping was inconsistent and some people's medicines had not been given timely. The audit process was new and not embedded into practice. Monitoring systems had not identified all the issues we found on inspection and due to the lack of an improvement plan it was not clear what actions were being taken to address shortfalls.

People told us they felt safe using the service. Staff had been recruited safely, with all necessary pre-employment checks completed. Staff had completed training in safeguarding and knew how to report concerns. Risks to people had been considered, although more detail was needed on the assessments, to ensure staff had all the information they needed to keep people safe.

Overall people said they were happy with the service and knew who to speak to, to raise any issues. Communication was reported to be an issue at times, both in terms of getting through to office staff and language barriers between people and some care staff. People's views had been sought through telephone surveys and discussions, although not everyone we spoke with could recall this taking place.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 21 September 2021) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We carried out a focused inspection of this service in August 2021, due to receiving concerns about call timings, late or missed visits, medication, recruitment checks and the use of restraint. Breaches of legal requirement were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-Led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last comprehensive inspection (published January 2020) to calculate the overall rating. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

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

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to person centred care, medicines management and the audit and governance process at this inspection.

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

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 also meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below

Greater 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
The inspection was carried out by two inspectors, two medicines inspectors and an Expert by Experience who conducted telephone calls with people using the service and their relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in [their own houses and flats] [and] [specialist housing].

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

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

Notice of inspection
We gave a short period notice of the inspection. This was to ensure the registered manager was available to support the inspection and to ensure we had prior information to promote safety due to the COVID-19 pandemic. The notice period also allowed the provider time to start asking people using the service and their relatives, if they would be prepared to speak to us about their experiences. Inspection activity started on 03 August 2022 and ended on 07 September 2022, by which time we had sought the views of people, relatives and staff and reviewed all additional information sent following the visit. We conducted office visits on the 05, 16 and 25 August 2022.

What we did before the inspection
We reviewed information we had received about the service since it was registered. This included notifications sent to us by the service. Notifications are changes, events or incidents that the provider is legally obliged to send to us without delay. 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. We sought feedback from the local authority and professionals who work with the service. We used all this information to plan our inspection.

During the inspection
We spoke with five people using the service and seven family members about the experiences of the care provided. We visited three people in their homes to speak to them and/or their relatives and look at medicines. We spoke with the registered manager, quality assurance lead and two directors in person and sought the views of 10 care staff via emailed questionnaires, four of whom responded.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at audit and governance information, care records, call monitoring data, staff rotas, medicine records, accident and incident data, safety records, infection control information, training records and meeting minutes.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

At the last inspection the provider did not have systems in place to ensure the accurate auditing of call monitoring records, and appropriate recruitment checks had not always been completed. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17. However, we identified issues with the timings of people's care visits which constitutes a breach of regulation 9 (Person centred care).

● People's care visits had not consistently been completed in line with the agreed times on the care plan. Call monitoring data provided by the service, showed some people's visits occurred later than scheduled. The length of the visits also varied, with some staff not staying for the planned duration.
● We also found call times, recorded in the daily notes carers completed during care visits, did not always tally with visit times on the call monitoring log, so we were unable to be sure what time some visits took place.
●People and relatives provided mixed feedback about care visits. One told us, "Everyday they (carers) come on time and do everything." Whilst another stated, "Timekeeping used to be okay, but not now, can be 40 minutes to an hour late. Last time this was discussed with the office, carers still arrived late the next day."

The completion of people's care visits was not always in line with the agreed times as stated on their assessment and care plan. This is a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited safely. Pre-employment checks were completed to ensure applicants were of suitable character to work with vulnerable people. This included completing checks with the Disclosure and Barring Service, seeking references from previous employers and ensuring staff were legally permitted to work in the United Kingdom.

Using medicines safely

At the last inspection the provider had failed to ensure medicines were being managed safely. This was a

breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● The provider did not have a safe process to check what medicine a person should be taking, as they did not always have the complete list of medicines. Not having an accurate record increased the risk of medicine errors.
● Medicines Administration Records (MAR) were not always clear or completed fully. Missing signatures meant it was not clear whether people had received their medicines. We also found staff used a code of 'O' without any explanation of why the medicine had not been given.
● Body maps were in place to record where a medicines patch had been applied, however, staff were not moving the patch to a new place of skin correctly. This could have led to side effects and skin irritation.
● One person who had medicines prescribed to be administered at specific times to relieve the symptoms of Parkinson's Disease, were not always given these at the prescribed times, due to carers arriving later than scheduled.

We found no evidence people had been harmed, however, medicines were not being managed safely. This was a continued breach of regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

At the last inspection the provider had failed to ensure infection control guidance was being followed correctly. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

● The provider had up to date infection control policies in place. Current COVID-19 guidance around risk assessments, PPE usage and staff testing were being adhered to.
● People told us staff wore the necessary PPE when providing care. Comments included, "They always wear PPE" and "PPE is always worn and always available."
● Staff confirmed they had received training in infection control, COVID-19 and the use of PPE.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At the last inspection the provider had failed to ensure systems were in place to ensure the accurate auditing of risk assessments. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17.

● Care files contained a range of risk assessments, covering areas such as manual handling, health and safety, mobility and medicines.

● However, these did not always clearly explain what the risks were, how they impacted on the person's safety and what control measures were in place to minimise each risk.
● Care plan audits had identified some of these concerns, with updated care plans containing more detail around risks and their impact. However, further work was needed to ensure control measures were consistently documented.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe using the service and being supported by its staff. Comments included, "I do feel safe, I'm particular about who comes into my house", "I would say that [relative] is safe" and "Yes, I do think [relative] is safe. We had some issues in the beginning, but the carers we have now are very good."
● Staff had received training in safeguarding and knew how to identify and report concerns.
● The service had an up to date safeguarding policy and the registered manager was aware of the local authorities reporting guidance. A log was in place to document any referrals and action taken.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At the last inspection the provider had failed to ensure quality monitoring systems were robust. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- A new audit process had been implemented; however, this was not yet fully embedded into practice. Decision making around the type and frequency of audit completion was also unclear.
- The audit schedule provided on inspection did not include all the checks being completed, those that were listed where only planned to be completed bi-annually. Such timescales would impact on the providers ability to identify issues timely.
- The new audit process had been in place since June 2022. Prior to this, it was unclear what monitoring and checks had been completed, as no evidence of audits or monitoring was provided by the service either during or after the inspection.
- The current audit process had identified some of the issues we found on inspection, such as inaccuracies and lack of detail in care plans, but not others such as the issues with medicines management.
- The provider agreed at the last inspection to ensure de-registration forms were submitted for a previous manager, who was still registered with CQC as managing the service despite no longer doing so. At the time of this inspection, these forms had still not been submitted.

Systems and processes to monitor the safety and quality of service provision, identify issues and ensure actions and regulatory requirements were addressed timely, were not robust or fully embedded. This is a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People and relatives provided mixed feedback about their involvement in their care and support. Some told us phone calls or visits to ensure the service was meeting their needs had taken place, others could not remember being asked for their views. One relative was unhappy the care plan had recently been updated without either them or their family member being consulted or informed.
● Similar feedback was provided regarding circulation of questionnaires or surveys. One relative stated, "Someone came to do a spot check and I did a questionnaire over the phone". Another told us, "I've never been sent a questionnaire." There was a lack of systems in place to demonstrate everyone's views had been sought.
● We identified a lack of detail in care plans surrounding people's communication needs, such as how staff would communicate with people who did not speak English. Similarly, some people and relatives we spoke with raised concerns about some carers not speaking or having limited English and the impact this had on effective communication during care visits. We saw no evidence people's preferences around this had been sought.
● Despite the inconstant feedback around involvement, all but one of the people we spoke with said overall they were happy with the service.

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 was aware of their responsibility regarding duty of candour. Duty of candour ensures providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment.
● Overall, people and relatives were happy with how concerns or issues had been dealt with and told us they felt listened to. One relative stated, "They listen to [relative] and are quiet open."

Working in partnership with others
● We noted some examples of the service working in partnership with stakeholders and other professionals, such as social workers and district nurses, in support of people using the service.

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 9 HSCA RA Regulations 2014 Person-centred care Call monitoring information, daily notes and feedback from people and relatives showed the completion of people's care visits was not always in line with the agreed times as stated on their assessment and care plan.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found no evidence people had been harmed, however, medicines were not being managed safely. Record keeping was inconsistent, including completion of MAR and records of people's prescribed medicines, and some people's medicines had not been given timely or administered correctly.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes to monitor the safety and quality of service provision, identify issues and ensure actions and regulatory requirements were addressed timely, were not robust or fully embedded.