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

Greater Manchester is a domiciliary service which provides personal care to people (including children) living in their own houses and flats. The service is operated by Rings Homecare Ltd. At the time of this inspection the service was supporting approximately 55 people. 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.

People's experience of using this service and what we found
People who used the service and their families raised concerns with us about the timeliness of care visits which on occasions, had impacted on the care people received. People did not always receive their medication safely due to sufficient time not always being left between visits and people's medication administration records (MAR) were not always fully completed.

People raised concerns with us about staff not always wearing the correct personal protective equipment (PPE) when arriving to provide their care. Although disclosure and barring service (DBS) checks were undertaken, they did not always cover staff to work with children. Some care plans and risk assessments lacked specific details about people's care. There were gaps in call monitoring logs, where entries had not been made to show what time staff arrived at and left a care visit. We have made a recommendation that staff complete training regarding the use of restraint.

Improvements to governance systems were required to ensure they were effective in identifying some of the concerns found during the inspection. Since the last inspection, the service had changed office locations, although, had not registered this location with CQC before moving. The service had two managers registered with CQC, although, steps had not been taken for one of them to de-register. We had not been notified about a safeguarding allegation of financial abuse that had occurred. We asked the registered manager for this to be submitted to us urgently.

There were systems in place for people who used the service and staff to provide feedback about their care through surveys and meetings. The staff spoken with during the inspection told us they felt the service was well-led.

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 good (published January 2020). At this inspection, this rating had not been sustained and the provider was found to be in breach of regulations.

Why we inspected
The inspection was prompted in part due information of concern we received from several whistle-blowers prior to our inspection. This included concerns raised regarding call timings, late or missed visits,

medication, recruitment checks and the use of restraint. A decision was made for us to examine those risks. This report only covers our findings in relation to the key questions safe and well-led which contain those requirements.

Prior to this inspection we reviewed the information we held about the service. No areas of concern were identified in the other key questions (Effective, Caring and Responsive). We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvements.

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

Follow up
We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Enforcement
We have identified breaches in relation to safe care and treatment and good governance. Please see the action we have told the provider to take at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

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 Care Act 2014.

Inspection team
This inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes.

The service had two registered managers with the Care Quality Commission. One of the registered managers had not been undertaking the role for quite some time, although had not de-registered themselves despite still working at the service. We asked the current registered manager to ensure this was done. This means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The inspection was announced. We gave the service 48 hours' notice of the inspection. This was because we needed to be sure the provider, or registered manager would be in the office to support the inspection.

Inspection activity started on 9 August and finished on 12 August 2021.We visited the office on both of these dates. Further inspection activity was completed via telephone and by email, including speaking with people who used the service, relatives and reviewing additional evidence and information sent to us by the service.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from professionals who worked with the service, including Bolton local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with 13 people who used the service and nine relatives about their experience of the care provided. We spoke with eight members of staff including the registered manager, office manager and six care staff.

We reviewed a range of records. This included 10 people's care records, a selection of MAR's and eight staff recruitment files. A variety of other records relating to the management of the service were also considered as part of the inspection.

After the inspection
We continued to seek clarification from the service to validate evidence found following our site visit.

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 the last inspection this key question was rated as good. At this inspection this has deteriorated to 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; Assessing risk, safety monitoring and management;

- Since our last inspection of the service in 2019, the service had begun providing care to children under the age of 16 years. In advance of our inspection, we received information of concern that staff were not recruited safely, with DBS checks not undertaken for staff providing care to children.
- We reviewed this concern as part of the inspection and looked at eight staff recruitment files. Although enhanced DBS checks had been completed and no criminal convictions identified, they did not include checks for working with children for some staff. The registered manager had been made aware of this prior to our visit and had made applications for these to be updated immediately. We have addressed this concern in the well-led section of this report. We found other recruitment checks had been completed as required. Staff confirmed they were asked to complete all necessary recruitment checks before starting their role.
- Prior to our inspection we had been made aware that some planned visits to people were either missed or late. We looked at the missed visits/near misses log held by the service which showed 11 had occurred in 2021, some of which had impacted on people's care, for example missed medication and in one instance, a person was left overnight in their chair.
- In some cases, there had been valid reasons why the visit had been late, such as if staff were stuck in traffic, or had to stay longer than planned at a previous call Efforts had been made by the service for other staff to attend and provide care where possible.
- People who used the service and their relatives raised concerns about call timings, although staff we spoke with said they felt there were enough staff working for the service and that their rotas were managed effectively. One person said, "They [staff] can be a bit late sometimes if they get held up at the call before me. Staff ring me if they can, but about 12 months ago, my evening call was missed altogether, and nobody told me why. I did call the office to check what was happening and someone turned up two hours later." A relative added, "There are some lovely staff but some of the organisation is a bit hit and miss. Some are regular, some are new and there are definite issues with timing. One didn't show up at all for one call and another came at 10.20am for the 8-9am call."
- The service used a call monitoring system to check people's calls were completed correctly and at the right times, however these were not completed accurately. In some cases, the system did not show what time staff had arrived and left and in others, staff had failed to log in and out at all, making it difficult to determine the accuracy the times people had received their care visit.
- People had a risk assessments in their care plans to help keep them safe. These covered moving and handling, the living environment, falls and fire safety. One person who used the service required their drinks to be thickened because they had been assessed as being at risk of choking. However, their care plan did not contain any information for staff to follow about this and a choking risk assessment had not been

completed.

Systems were not in place to ensure accurate auditing of call monitoring records, care plans and risk assessments. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely; Preventing and controlling infection;
● Prior to our inspection we received information of concern about people not always receiving their medication safely on occasions because of the timeliness of people's care visits. One family raised concerns with us about staff not leaving sufficient amounts of time between visits where paracetamol needed to be administered approximately every four hours. The person's family had to give the person their medication themselves at times due to delays. We checked this person's call monitoring logs and daily records and saw on some occasions staff had arrived within three hours to administer the medication again.
● Some people's MAR had unexplained gaps, making it difficult to establish if people had received their medication as prescribed. Concerns had been raised about certain medication not being administered before food during morning visits. We were told by one family, "[My relative} needs certain medication on an empty stomach. By chance, she usually hasn't eaten when the staff arrive, although they don't ask."
● We looked at the systems in place regarding infection control. We found staff were completing weekly tests as required. The registered manager maintained a record of the results. Staff confirmed they completed regular testing and had received both COVID-19 vaccinations.
● Staff told us they had sufficient PPE available, however some of the feedback we received from people who used the service was that it wasn't always worn during care visits. One person said, "Odd staff are still not coming masked-up and we are sure some are using the same PPE for personal care and feeding." Another relative added, "We have had some staff turn up without gloves and masks. One staff member was wearing a headscarf instead, as they said that was what she always wore."

Medication was not being administered safely and infection control guidance was not always being followed. This placed people at the risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Prior to the inspection, we received information of concern about a person being restrained during a care visit by staff. We asked the registered manager to provide us with an overview about what had happened, and were told the person had not been restrained, although staff had held the person down as they were being resistive to care. This would be classed as a form of restraint.

We saw staff had not completed restraint training and recommend this is undertaken.

● People who used the service told us they felt safe as a result of the care they received. One person said, "I have no complaints and feel perfectly safe with the staff that come. My spouse enjoys some space too, so it works well for us."
● A safeguarding policy and procedure was in place. Staff had an understanding about whistleblowing and safeguarding, and about the different types of abuse that could occur. One member of staff said, "I have had this training and this was done face-to-face and then an on-line refresher. I am aware of whistleblowing but have never needed to use it. Safeguarding could be like changes of behaviour, staff bad practice and wrong medication. I would tell the manager straight away if needed."
The training matrix showed staff had completed both safeguarding training for both adults and children.
● Accidents and incidents were recorded, with actions taken to prevent future re-occurrence.

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 the last inspection this key question was rated as good. At this inspection this key question has deteriorated to 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.

Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- We looked at the systems in place to monitor the quality of service effectively. Some audits were completed for areas such as medication and care plans. However, we found they required improvement due to not identifying the concerns found during this inspection.
- For example, it was other health care professionals who highlighted appropriate DBS checks had not been completed for staff working with children. Medication audits did not provide a focus on any gaps within people's MAR, medicines being taken with food and time specific medicines. Audits of people's call monitoring logs and care plans had not identified times were not accurately recorded for people's care visits and if relevant risk assessments and care plan information were documented.

Quality monitoring systems were not robust. This placed people at the risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Systems were in place to involve people using the service, relatives and staff in how the service was run. This included the use of satisfaction surveys to obtain feedback and reviews carried out with people over the telephone.
- Further quality monitoring systems were in place through the use of spot checks/observations of staff and competency assessments.
- Staff meetings and supervisions were also held so that feedback could be sought and used to make improvements. A member of staff said, "I feel the managers are good and we have meetings and face to face supervisions about every three months."

Managers and staff being clear about their roles and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Since the last inspection, the service had changed offices, but had not registered the new location with CQC before moving. This meant the current location was incorrectly registered. We asked the provider to submit these forms to change the location urgently.
- The service had two registered managers in post but had not completed the process to de-register one from the location. We asked that this process be completed during the inspection.

● We asked people using the service for their views of management, leadership and if they had any concerns about the availability of the registered manager. One member of staff said, "I think they are doing very well, and they help me in my job and always answers when I ask things. They always ask us about our service users and the manager asks for our feedback on things." Another member of staff said, "If we have any concerns, we can raise them with managers at any time. All staff involved in a person's care may be called to a meeting to discuss any issues arising and management do listen to me."
● People who used the service and relatives were complimentary about the care provided which ensured good outcomes were achieved.

Working in partnership with others;
● The service worked in partnership with various local authority's and health teams in the local area.

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 12 HSCA RA Regulations 2014 Safe care and treatment Appropriate systems were not in place to provide safe care and treatment, particularly regarding medication and infection.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Appropriate systems were not in place to ensure good governance, particularly regarding maintaining accurate/contemporaneous records and monitoring the quality of service effectively.