Riccall Carers Ltd

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Riccall Carers Limited is a domiciliary care agency which provides personal care, companionship and assistance with everyday tasks to people living within the York and Selby areas. The service supported people with a range of needs including those living with dementia, people who have a learning disability or Autistic Spectrum Disorder and both older and younger people. There were 176 people being supported at the time of our inspection

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
We found multiple concerns at this inspection which could compromise people's safety and impacted on the quality of support people received.

The provider had not established an effective system to monitor the quality and safety of the service people received or to drive the necessary improvements.

Accidents and incidents had not always been reported or followed-up to ensure actions had been taken to mitigate risk for people. Risk assessments were not always in place when risks to people had been identified. When risk assessments had been completed, they lacked detail to guide staff in how to reduce the risks. Safeguarding concerns had not always been raised to enable investigations by the relevant agencies. Medicines had not been managed safely. People had not received their medicines as prescribed which impacted on people. Audits completed had failed to identify the extensive concerns we found with medicines management during the inspection.

People who used the service and staff told us care calls were frequently cancelled, late and on occasions, missed. People didn't always know who to report their concerns to. When concerns had been reported, they received no follow-up to advise of the actions taken.

People who used the service told us most of the carers were kind, but calls were sometimes rushed. Staff told us they did not feel supported to enable them to perform their duties and were unclear as to people's roles and responsibilities.

The provider took immediate actions to address urgent concerns about people potentially been at risk of harm. We requested the provider send an update as to the actions been taken to ensure the safety and improve the quality of the service.

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

Rating at last inspection
The last rating for this service was Good (report published 15 May 2019).

Why we inspected
This was a planned inspection based on the previous rating and intelligence around potential risk.

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

Enforcement
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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

At this inspection, we have identified breaches in relation to safe care and treatment, safeguarding, good governance and staffing.

Full information about CQC's regulatory response can be found 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Riccall Carers Limited

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
Two inspectors conducted the first day of inspection and one inspector attended on the second. Three inspectors undertook staff phone calls. Two Expert by Experience (ExE) telephoned people who used the service and / or 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 homes.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This gave the provider time to make arrangements for us to speak with people who used the service and staff.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and considered other forms of feedback we had received. 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. We used all of this information to plan our inspection.

During the inspection
We spoke with 10 people who used the service and seven relatives about their experience of the care provided. We spoke with 18 members of staff including the registered manager, directors, operations

manager, care co-ordinator, assessment and review officer, recruitment officer, human resources administrator and carers. We also spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at three staff files in relation to recruitment and their induction. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found and were provided with updates about the urgent actions we had requested were undertaken.

Inadequate

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 key question has deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

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

- There was no formal process for reporting or following-up on accidents and incidents. Incidents had occurred which the registered persons were not aware of. This included a person who was described as having nearly choked. Immediate actions were taken during and following the inspection.
- The provider' accident and incident policy was not in line with staff practice within the service.
- There was no overview of accidents and incidents. Incidents were not consistently reviewed to establish the details of what had happened and whether any learning could be applied.
- Risk assessments were not consistently in place for identified risks. This included, risks relating to COVID-19, bed rails and choking. Whilst some risk assessments were in place for some areas, they lacked information to guide staff about the actions required to mitigate identified risks.

A failure to assess monitor and manage risk was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- There were numerous people who had not received their medications as prescribed. This included medication for pain relief and the management of diabetes. Some people had been adversely affected as a result of this. We requested safeguarding concerns were raised for some of the errors.
- When medicines had not been administered correctly, appropriate follow-up actions had not always taken such as seeking the advice of a healthcare professional.
- Staff who administered medicines had not always been trained. For staff who had undertaken training, their competency to administer medicines was not routinely assessed.
- A medicines audit was last completed in April 2021. This audit had not highlighted the issues we found on inspection. The registered persons did not have oversight of the medicine's administration procedures.

Failure to ensure the proper and safe use of medicines was a breach of Regulation 12 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 protected from future harm because safeguarding concerns had not always been raised when there were concerns about a person's well-being.
- There was limited overview of any concerns received to ensure these had been shared with the relevant agencies and all the necessary actions taken to protect people from potential abuse.
- Staff understanding and knowledge in this area was not consistently checked and training had not been

undertaken.

Failure to protect people from abuse and improper treatment was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment
● People who used the service and their relatives told us their calls were routinely late, missed and / or cancelled. Relatives described repeated requests to provide support due to carers been unavailable. For example, a relative told us, "If a carer is ill, or on holiday they have difficulty finding someone to replace them; they ring me and ask me to cover."
● People didn't know which staff member was coming to the support them, and rotas were often left blank. This affected people's continuity of care. A relative told us, "In the mornings [person's relative] has a regular carer, though sometimes they have had a complete stranger." On occasions, male staff were supporting people who had requested the support of females only.
● Staff described feeling rushed and not having enough travel time between calls.
● Staff did not have sufficient time between calls and they told this meant some people missed their medication.

A failure to deploy sufficient numbers of staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● Staff advised they had undertaken training in infection control and had access to appropriate PPE.

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.

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

- Quality assurance processes, to monitor the safety of the service, were not in place. This had resulted in the regulatory requirements been unmet and people been exposed to increased levels of risk. The provider acknowledged our concerns and were in the process of drafting a new quality assurance process.
- Improvements were not been driven due to the limited oversight of incidents, complaints and staff practice and learning which could be applied from these.
- There was a lack of clarity about people's roles within the organisation. Staff and people we spoke with described not knowing who to speak with when they had concerns. Staff told us, "I couldn't tell you who does what anymore" and "You don't know who to contact in the office if you've got any problems." When concerns were raised, these were not always been addressed.

Failure to establish and operate effective systems was a breach of Regulation 17 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Staff didn't feel supported in their role. A staff member told us, "There is no support network for staff." Some staff advised they had not received supervisions in approximately two years. Staff described occasions whereby they had needed guidance or support to care for somebody, and they were unable to contact anybody.

A failure to support staff to enable them to perform the duties involved in their role was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There were limited opportunities for staff and people who used the service to feed back about their experiences. The last survey seeking people's opinion on the service was in 2019. People told us when they had raised concerns or complaints, they did not always have a response to these.
- Some people who used the service were positive about the impact some carers had made to their lives.

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

● As investigations relating to accidents or incidents were not undertaken, the provider was not always aware when things had gone wrong to ensure this information was shared transparently with the correct people and agencies.
● The provider acknowledged the significant shortfalls within the service.

Working in partnership with others
● Carers had worked with health and social care agencies and, sought their advice and guidance in relation to people's care.

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 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care had not been provided in a safe way. Medicines were not managed safely. Risks were not always assessed along with ensuring the relevant actions taken to mitigate such risk. Regulation 12 (1) (2) (a) (b)

The enforcement action we took:

Notice of Decision to impose urgent conditions on registration.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA RA Regulations 2014 Safeguarding Service users had not been protected from abuse or improper treatment. Systems had not been established or operated effectively to prevent the abuse of service users. Regulation13 (1) (2)

The enforcement action we took:

Notice of Decision to impose urgent conditions on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance.

	Systems or processes were not established or operated effectively to ensure compliance with the regulations. Processes to assess, monitor and improve the quality of the service were not in place. Risks were not assessed or monitored and mitigating actions had not been taken. Feedback had not been sought ti evaluate and continually improve the service. Regulation 17 (1) (2) (a) (b) (e)

The enforcement action we took:

Notice of Decision to impose urgent conditions on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of staff were not suitably deployed. Persons employed did not receive appropriate support to enable them to carry out their duties. Regulation 18 (1) (2) (a)

The enforcement action we took:

Notice of Proposal to cancel the provider's registration.