

RT-Care Solution Limited

Main Office

Inspection report

147 Narborough Road
Leicester
LE3 0PD

Tel: 07863667722
Website: www.rtcaresolution.com

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Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service

Main Office is a domiciliary care service providing personal care. The service provides support to older people living in their own homes. At the time of our inspection there were seven people using the service.

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 were not kept safe from the risk of harm. The provider failed to identify risks to people, which placed them at increased risk of harm. The provider failed to implement robust systems to assess known risks to people. People's medicines were not managed in line with good practice. The registered manager failed to ensure robust pre-employment checks were undertaken prior to staff working at the service. The registered manager failed to learn lessons when things went wrong.

People did not receive effective care. Staff did not always receive appropriate training to allow them to effectively carry out their role. Mental capacity assessments did not contain the required information and did not meet the expectations of the relevant legislation.

The service was not always caring. Whilst relatives told us their family members were looked after well, the culture of the service impacted on this, and placed people at risk of receiving care that did not always meet their needs.

People did not receive personalised care that reflected their needs and preferences. Care plans were inadequate and failed to give staff clear guidance on meeting people's diverse needs. People's communication needs were not always met.

There were significant and widespread concerns in relation to the management of this service. This meant that people did not receive care from a service that was well-led. The provider failed to implement systems and processes to ensure adequate governance and monitoring of the service.

People were not supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; and the policies and systems in the service did not support this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
This service was registered with us on 25 February 2019 and this is the first inspection.

Why we inspected

We inspected this service as part of our regulatory function.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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 monitor the service and will take further action if needed.

We have identified breaches in relation to keeping people safe from harm, safe recruitment and the management oversight of the service at this inspection.

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 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 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?

Inadequate ●

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement ●

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate ●

The service was not well-led.

Details are in our well-Led findings below.

Main Office

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 completed by one inspector.

Service and service type

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. At the time of the inspection, there were five people in receipt of personal care.

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 the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 27 June 2022 and ended on 20 July 2022. We visited the location's office on 27 June 2022 and 20 July 2022.

What we did before the inspection

We reviewed information we had received about the service. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider

information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke with two relatives of people using the service about their experience of the care they received. We spoke with five members of staff, including the registered manager and four staff members. We reviewed a range of records. This included three people's care records and medicine records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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

- The provider did not have robust processes to ensure all risks to people were identified and acted upon. For example, some people had been diagnosed with specific health conditions. Staff did not have clear guidance on how to manage these safely. The provider was unable to demonstrate staff had received training in these areas. Staff knowledge was poor when we spoke with them. This placed people at increased risk because staff did not have sufficient training to safely manage people's health conditions.
- Staff had contradictory information on people's needs. For example, we saw one person's risk assessment identified a high number of risks in their environment, however, their care plan stated there were no risks. One staff member said, "The care plans are good and accurate. I rely on them to tell me what to do." The reliance of staff on care plans that did not include details of risks and how to mitigate them put people at risk of receiving unsafe care.
- The provider had failed to identify risks associated with the use of catheter care. There was no guidance for staff on how to identify complications. For example, there was no guidance on how staff could identify a blockage or signs of an infection. This placed people at increased risk of infection and had required intervention by other healthcare professionals as care staff were unclear on how to provide safe care and treatment to people.
- Staff did not keep clear records of the actual times spent with people so the provider could not demonstrate people received their care visits in a timely manner. People told us they were happy with their visit times, however, did confirm staff did not come at the time written on the records. This was fed back to the registered manager who advised they sometimes went and conducted spot checks on staff to check the timeliness of care visits.

Using medicines safely

- Medicines were not managed safely, and a lack of information meant staff did not have correct guidance to follow. Medicine care plans did not accurately describe the level of support people required. For example, one person's medicine care plan stated they required three different levels of support with medicines. The person did not have capacity to be able to tell staff what medicine they needed. There was no further information on what these levels of support entailed.
- Medicine records did not contain accurate information. For example, we saw one person's medicine record had been signed for by the same staff member for the whole month. However, when we checked against the daily care notes, the staff member had not provided care at the person's house for that month. This meant the provider could not be assured of the credibility of the MAR chart, nor that the person had received their medicines appropriately.
- Staff did not have the appropriate guidance to follow to be able to administer 'as required' medicines to people when they needed them. The provider did not follow relevant national guidelines in relation to non-

prescribed medicines that it managed for people. This meant staff were unclear on when these medicines should be administered and how to do this safely.

- The provider failed to follow correct procedures when people lacked capacity to make decisions about taking medicines. For example, one person had a mental capacity assessment which recorded they lacked capacity. There was no capacity assessment for medicine administration, or guidance for staff should they need to administer medicines without the person's knowledge or consent.

People were at risk of not receiving safe care and treatment. People had also been placed at risk of harm as medicines were not managed safely. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- The provider did not follow safe recruitment processes. This meant people were at risk of being supported by staff who were not of good character, or had the necessary competence, skill or experience to support people safely.
- Staff were not always safely recruited. The provider did not have a robust recruitment system to ensure suitability of staff employed. We reviewed four staff files and found they did not contain information to demonstrate the required pre-employment checks had been undertaken prior to care staff starting work. The provider had failed to obtain all legally required information prior to employing staff members. For example, not all files contained employment history, evidence of interview or references from previous employment.
- Staff recruitment files did not always contain employment history, so the provider did not have oversight of previous experiences which staff members held. This meant gaps in staff knowledge had not been identified or acted upon.

Required checks to ensure care staff were suitable to work at the service had not been completed. Failure to have systems and processes in place to recruit staff safely is a breach of Regulation 19 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;

- The provider did not have robust systems in place to protect people from the risk of abuse. People told us they felt safe and staff had completed safeguarding training; however, the provider had failed to identify and report safeguarding incidents. Records had not been made of safeguarding incidents that had occurred since the service began, or any system implemented to monitor this. Systems and processes were not operated effectively to help ensure people were kept safe from abuse and risk of avoidable harm.
- The provider did not have a system to record accidents and incidents and no system to monitor and review for trends and to learn lessons when things had gone wrong. Staff told us they did not know of any formal system to record accidents and incidents but stated they would record it on the person's daily care notes if one occurred. This meant the provider would not know if an incident or accident had occurred.

Preventing and controlling infection

- We were not assured that the provider's infection prevention and control policy was up to date. This is because the isolation information contained within it has been replaced by alternative guidance.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for staff.

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 requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff did not always receive appropriate training for their role. The provider's training matrix showed staff had received mandatory training, however, staff had limited knowledge on how to meet some people's care needs. Staff stated they had received training for diabetes, however the provider could not evidence that this training had been completed. Staff were also not clear on the safe sugar levels for people they support. This meant people were at risk of staff not identifying if the person was becoming unwell due to blood sugar levels which were too high or too low.
- The provider failed to complete competency checks for staff to ensure staff knowledge and practice was in line with current standards. This meant people were at risk of not being supported by staff effectively.
- Staff told us they received an induction before supporting people unsupervised. The provider's induction training consisted of a mixture of online modules and face to face training. This meant staff had a basic understanding of their role before they started work.

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.

- We reviewed one person's mental capacity assessment which the registered manager had completed. This did not follow the principles of MCA. This is because it was not for a specific decision and referenced decisions relating to multiple areas of the person's care. It also contained contradictory information so the provider could not be assured the assessment was accurate and related to the correct person.
- The mental capacity assessment did not identify whether the person had a Lasting Power of Attorney.

There was a risk the appointed person would not be consulted in any relevant decisions should the person not have the mental capacity to make them on their own. This meant there was a risk the person's rights would not be upheld.

- The Best Interest decision section did not describe how staff could support the person in the least restrictive way. There was no further information available for staff to follow on how to support the person in their best interests, and there was no information on how the decision had been reached. This meant staff did not have clear guidance on people's decision-making abilities and how to support them in their best interests.

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

- People's needs were not always fully assessed. The provider did not complete comprehensive assessments

for people they supported. Assessments lacked detail which impacted on staff providing person centred care. For example, one assessment described how a person had hearing loss. There was no information for staff on how to communicate effectively with this person.

- Summary care plan information conflicted with people's main care plans. This did not support staff to fully understand people's needs.

Supporting people to eat and drink enough to maintain a balanced diet

- People were at risk of not receiving adequate nutrition and hydration. Daily records showed staff prepared food and drink for people when requested. However, a person using the service had a health condition which meant they could not always convey their preferences or needs. Existing staff members knew the person well, however care records did not include information about the person's preference of food and drink, to guide new staff. This placed people at risk of dehydration and malnutrition and at risk of receiving inconsistent care as there was no written care plan information for staff to follow.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support;

- The registered manager told us they worked alongside other professionals such as district nurses, social workers, and the crisis team to deliver holistic care to people.
- The registered manager provided examples of how they had consulted other professionals when there had been changes in people's needs. For example, liaising with the local authority to request further care visits for the person.

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

- Whilst feedback from people was positive, care records did not provide information for staff on how to deliver person centred care in the way people wanted. This posed a risk people would not be supported in the ways they wanted to be.
- Relatives told us staff were caring. One relative described staff members as, "Very friendly, very nice, very caring, trustworthy, efficient, don't let you down, good at their jobs." However, staff had not taken care around the recording of people's care notes, and they did not have evidence that people had received care that was specific to them.
- Staff knew the people they supported and strived to keep people happy. One staff member told us, "I try to get here as early as I can as I know they love the company." However, people's individual likes and preferences were not always recorded in their care plans and associated risk assessments. This meant new staff would be unclear on how best to support people in the way they preferred. This is particularly important where people do not have the capacity to be able to express decisions about their care.
- The registered manager had a good understanding of equality and diversity, and how to be respectful of people's religious wishes during care. The registered manager said, "We treat each individual according to his or her belief, we don't discriminate."

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

- Relatives told us their family members were involved in decisions about their care. However, where the MCA applied to people, we were not assured their relevant legal representative would be involved in decision making.
- The registered manager described how they involved people in reviews of their care, and how adjustments were made when a person's needs change.
- The registered manager advised they signposted people to advocacy services when needed, however we did not see any evidence of this

Respecting and promoting people's privacy, dignity and independence

- The registered manager described how they encouraged staff to treat people well. The registered manager told us, "I discuss with them, you must treat that person with compassion, kindness, dignity and respect. That is always my words to the staff."
- The registered manager also explained how they promoted dignity for the people they supported. They said, "For example some men, don't like personal care with female staff, so we send the male carer."
- Relatives advised staff treated their family member with respect. One relative said, "My [family member]

really likes them, they say [the staff members] are wonderful."

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

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

- People's care plans lacked sufficient information to be able to guide staff to provide person-centred care. Care plans were often generic and often contained information regarding other people. This meant that new staff would have difficulty delivering personalised care to people.
- People's needs were not fully considered by the service. For example, initial assessments completed were not detailed and failed to identify people's preferences and needs. This meant the provider was not able to plan how to meet these preferences and needs.

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.

- Staff did not have information on how to support people in the best way or respond to their needs because people's communication care plans and risk assessments did not describe their needs in relation to communication. For example, one person had a sensory impairment. Whilst their care records identified this, there was no information to guide staff on how to communicate with the person.

Improving care quality in response to complaints or concerns

- The provider stated they had not received any concerns since their time of registration. People we spoke with confirmed they had not made any complaints but knew how to make complaints if needed. The provider had a complaints policy in place.

End of life care and support

- At the time of the inspection, none of the people using the service required end of life care and support. The provider advised they had recently been caring for a person in the end stages of their life. The registered manager explained they had increased care visits in line with the person's increasing needs. However, during the inspection, we identified a lack of information in care plans and a delay in responding to changes in people's needs. We are concerned that processes of recording changes in needs may not be completed in a timely way, resulting in people receiving inappropriate support during the final stage of their life which was not aligned with their wishes.
- It is also a requirement of the provider to submit a notification to the Care Quality Commission when a person using the service has passed away. The registered manager had failed to submit the notification for

the person they had recently been caring for. When this was pointed out at the inspection, the registered manager immediately completed and submitted the notification.

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

- There were significant and widespread shortfalls in the leadership of this service. The registered manager and nominated individual did not have clear oversight of the service. They had not identified the shortfalls we found on this inspection. This had adversely impacted on the care people received.
- Systems and processes designed to identify risks to people were not effective and care plans did not contain sufficient guidance to support staff within their role. The registered manager failed to complete staff supervision and carry out competency checks in a timely manner. Staff were unclear about how they were performing within their role and lacked guidance from the registered manager on ways in which they could improve.
- Systems and processes to ensure the quality and safety of medicines management were ineffective. The provider could not evidence that people received time critical medicines at the appropriate times. Medicine records lacked detail and contained errors and inconsistencies. The provider had failed to follow their own medication administration record policy, and there was no over-arching medication policy in place to guide staff in the safe administration of medication.
- The provider's recruitment processes did not ensure recruitment files contained all of the information which is required by law. The provider had failed to follow their own recruitment and selection policy. This meant the provider could not be assured they were employing safe staff. This was raised with the registered manager on the first inspection day, however when we returned for the second inspection day, no changes had been made to staff recruitment files. We remain concerned that action was not taken in a timely way to improve the quality and safety of the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider's systems to assess, monitor and improve the quality and safety of services were not effective. Records were not accurate or complete. Care plans did not contain information to support staff to deliver person centred care. Care plans often contained information relating to other people. Staff were unable to describe the fundamental objectives of delivering person centred. Daily care records confirmed this, as they contained limited information and did not evidence that people were receiving care which was specific to them.

Continuous learning and improving care; 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

- Accidents, and safeguarding incidents had not been recorded, investigated or reported. The registered manager advised they had never needed to report a safeguarding incident, and that no accidents had occurred. During the inspection, staff and people told us about an accident which had occurred to a person using the service who had required an ambulance, and also about an incident which we would have expected to be reported as a safeguarding to the local authority. As a result of our inspection, we made three referrals to the local safeguarding board. The provider's systems to assess, monitor and improve the quality and safety of services and reduce risks were not effective as they had not followed local safeguarding protocols.
- No quality audits had been completed to ensure care was safe and effective. We raised this concern with the registered manager, and they produced a list of quality checks they intended to complete. However, there was no evidence these checks had been completed and there was no relevant organisational policy in place. A lack of quality oversight meant the provider had failed to monitor and improve the quality and safety of services.
- Not enough improvement had been made to the service between the first days of our inspection and the second day. The registered manager had been made aware of some concerns, however had failed to review care plans, recruitment files and internal systems and processes. This lack of reflective practice impacts on service improvement.
- The registered manager could describe their role in relation to duty of candour and understood their legal requirement to complete statutory notifications for the Care Quality Commission. However, due to systems and processes not being in place to allow sufficient oversight of the service, this meant that referrals to the local safeguarding board had not been made.

Systems and processes designed to assess, monitor and improve the quality and safety of services and reduce risk had not been operated effectively. Records were not complete or accurate. The significant lack of oversight and governance is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Working in partnership with others

- The provider did not always work in partnership with others. The registered manager was able to describe how they would work with other health professionals to ensure people were supported effectively. However, people's care plans did not describe which health professional to contact in the event of an issue with medical equipment. This meant if the registered manager was not available, staff would not have enough guidance to support their work.
- The registered manager had failed to follow their own policy and procedure in respect of safeguarding, including following local protocols to report safeguarding concerns.

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

- The registered manager had considered people's preferences and personal beliefs. For example, they described how one person did not wish to receive personal care from a staff member of the opposite sex, and so the staff member had been changed. However, care plans contained contradictory information about people's needs, and therefore did not support staff fully in supporting people's diverse needs.
- People and staff were happy with the care provided. They advised they had not needed to make a complaint but felt they would be listened to by the management team if they were unhappy.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>People were not kept safe from the risk of harm. The provider failed to implement robust systems to assess known risks to people. People's medicines were not managed in line with good practice. The registered manager failed to learn lessons when things went wrong</p>

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>There were significant and widespread concerns in relation to the management of this provider. This meant that people did not receive care from a service that was well-led. The provider failed to implement systems and processes to ensure adequate governance and monitoring of the service.</p>

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Personal care	<p>Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed</p> <p>The registered manager failed to ensure robust pre-employment checks were undertaken prior to staff working at the service.</p>

The enforcement action we took:

We imposed conditions on the provider's registration.