Pringle's Care Services Limited

Pringles Care Services - Central

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
Pringles Care Services - Central is a domiciliary care agency providing personal care and support to people in their own homes. At the time of the inspection the agency was supporting 42 people. Not everyone who used the service received personal care. In this service, the Care Quality Commission can only inspect the service received by people who get support with personal care. This includes help with tasks related to personal hygiene and eating. Where people receive such support, we also consider any wider social care provided.

People's experience of using this service and what we found
People and relatives told us they felt their care service was safe. However, the provider had not always assessed risks to people's health and well-being or done all that was reasonably practicable to reduce those risks.

There were assorted quality monitoring systems in place, but these had not always been effective as they had not enabled the provider to identify and address the issues we found. The provider did not always appropriately manage records about the service and people's care.

There were arrangements in place for preventing and controlling infection that were not applied consistently. The provider had not followed national guidance on staff COVID-19 testing. The registered manager addressed this promptly after the inspection.

There were enough staff to meet people's needs safely, but the provider did not always monitor staff attendance effectively. People were visited by the same care workers who they were familiar with and who knew their care needs. There were recruitment processes in place to help make sure only suitable staff were employed.

There were procedures to help people take their prescribed medicines. The service worked in partnership with other agencies, such as social workers and GPs, to help those agencies provide coordinated care to people.

For more information, please read the detailed findings section of this report. If you are reading this as a separate summary, the full report can be found on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection:
The last rating for this service was good (published 28 August 2018).

Why we inspected
We received concerns in relation to providing safe care and the management of the service. As a result, we

undertook a focused inspection to review the key questions of Safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. 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. Please see the safe and well-led sections of this report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Pringles Care Services – Central on our website at www.cqc.org.uk

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 safe care and treatment and good governance at this inspection. Please see the action we have told the provider to take at the end of the full version of this 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 work alongside the provider and 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.

Pringles Care Services - Central

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 one inspector and one 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 houses and flats.
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
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included information about the service and people's experiences shared with us by local commissioning authorities. We used the information the provider sent us in the provider information return. 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 of this information to plan our inspection.

During the inspection
Inspection activity started on 31 March 2022 and ended on 19 April 2022. We visited the location's office on 31 March and 1 April 2022. We spoke with the registered manager, deputy manager and quality assurance manager as well as two care coordinators and two field care supervisors. We viewed a range of records relating to people's care and the management of the service. This included five people's care and risk management plans and medicines support and care records. We saw three staff files in relation to recruitment and supervision. We viewed a variety of records relating to the management of the service, including audits, meeting records and procedures.

After the inspection
We requested further evidence and continued to seek clarification from the provider to validate the evidence we found. We spoke with three care staff, two people who used the service and relatives of four other people who used the service.

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 good. At this inspection we have rated this key question 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.

Assessing risk, safety monitoring and management, Preventing and controlling infection

- Risks to people's safety and wellbeing were not always assessed, monitored and managed so they were supported to stay safe.
- Staff handled some people's money when they did shopping for them. We saw this support was not documented in a person's agreed care plan. This was not in line with the provider's Service User's Finances Policy. Care staff were not completing clear financial transaction records when they handled the person's money and the provider could not demonstrate they regularly audited this support. The person told us they were happy with their shopping support and felt safe, but the arrangements meant the service did not always promote safe working with people when staff handled their money. We brought this to the registered manager's attention so they could make sure the person's care arrangements were appropriate.
- Some people needed help to mobilise and this included using mobility equipment such as a hoist, for example when moving from bed to a chair. The moving and handling risk assessments of this support for some people did not always clearly indicate how staff should support the people safely or what equipment they should use for this.
- The provider had arrangements in place for preventing and controlling infection, but these were not always implemented in line with national guidance.
- Staff were completing weekly lateral flow tests to identify if they had contracted COVID-19. However, Government guidance had required homecare staff to complete a test each day before they began their care visits. This meant the provider had not ensured that testing had been consistently implemented as required to reduce the risk of people contracting COVID-19 from staff who visited them. The guidance changed at the time of our inspection to a twice weekly testing requirement. We discussed with the registered manager and they instigated testing for care staff as required.

These issues indicated that risks to people's safety were not always assessed, monitored and managed so they were supported to stay safe. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Other assessments identified risks to people's safety and well-being and actions for staff to take to mitigate those risks. For example, when a person was living with a health condition such as chronic obstructive pulmonary disease, which can cause breathing difficulties.
- We saw the provider had responded to safety concerns that care staff had raised. For example, contacting healthcare services when a person's pressure relieving mattress was found to be faulty so that this could be corrected.
- The provider gave staff information and training on infection prevention and control, including guidance

about COVID-19. They had encouraged staff to receive COVID-19 vaccinations.
● The provider supplied staff with personal protective equipment (PPE) so they could support people safely. Care staff told us they always had enough PPE supplies. People said staff wore their PPE. Their comments included, "I've always seen them to wear aprons, masks, gloves" and "The carers are good with PPE."

Staffing and recruitment
● The provider deployed enough staff to support people to be safe. However, they did not always use the service's electronic call monitoring system (ECMS) effectively to monitor 'real-time' staff attendance and reduce the risk of people experiencing late or missed care visits.
● We reviewed the live ECMS during our visit and staff could not account for why a care worker had arrived three hours late for a person's scheduled care visit. They could also not demonstrate they had acted to ensure the person was safe until they were visited. We raised this with the registered manager so they could address this practice. We saw they were working to improve the use of the ECMS.
● Relatives we spoke with told us care staff were "usually on time" and the provider would let them know if care workers were running late.
● Daily care records showed that people were generally visited by the same staff. This meant people had an opportunity to develop a trusting relationship with the staff supporting them. One person, however, said this had not been the case recently and they had raised it with managers to address.
● Staff said they usually had enough time to travel between care visits and did not need to rush when supporting people.
● The registered manager had processes in place to complete a series of recruitment checks to make sure they only offered roles to fit and proper applicants.

Using medicines safely
● There were systems in place to make sure staff supported people to take their medicines as prescribed.
● Staff who administered medicines had completed training on how do this safely. The registered manager had assessed their competency to provide this support.
● People's care plans provided information about their prescribed medicines, such as how much a person needed to take, when and the potential side effects. However, staff supported a person to take medicines using a tube surgically placed in their stomach. Their care plan did not always provide clear direction for staff on how medicines needed to be prepared for this type of administration. We discussed this with the registered manager and signposted them to relevant guidance so they could address this. A relative told us they were happy with the person's medicines support.
● Staff completed the medicines administration records (MARs) to indicate they had supported people to take their medicines as prescribed. The MARs we viewed during our had been completed appropriately.

Systems and processes to safeguard people from the risk from abuse
● The provider had safeguarding policies and processes in place to protect people from the risk of abuse.
● When safeguarding concerns had been raised, the provider had engaged with the relevant statutory agencies to look into these to ensure people were safe. This included concerns that were being investigated when this report was being written.
● People we spoke with said they felt safe with their care. Staff had received training in safeguarding adults. Staff we spoke with told us how they would respond to and report safeguarding concerns. This included escalating concerns to statutory agencies.

Learning lessons when things go wrong
● The provider had a system for responding to and recording incidents and accidents. Staff recorded what had happened and the actions taken, including other agencies they involved. For example, calling

emergency services if a person had experienced a fall and conducting a falls risk assessment afterwards. The registered manager had reviewed and summarised these records to note learning for service improvements.

● The registered manager investigated issues when they identified things had gone wrong. This included issues we raised with them during this inspection.

● Staff we spoke with said they felt supported by their seniors when something happened. For example, if a person did not respond when they arrived for a care visit. One care worker said, "Each time you call for a solution they are always there."

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 good. At this inspection we have rated this key question 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

- The registered manager's systems for monitoring the quality of the service had not always been effective as it had not enabled them to identify and take timely action to address the issues we found.
- The systems had not maintained people's safety by ensuring safe care and treatment and through staff completing COVID-19 testing in line with Government guidance. This meant there was a lack of consistency in how the provider managed risks to the safety and quality of the service.
- The registered manager had not always ensured they maintained accurate, complete and contemporaneous records of people's care and the management of the service.
- Some people's risk assessments had been completed but it was not always clear how these had been used to inform decisions about managing risks to people. For example, a nutrition and hydration assessment had been signed by staff as completed but contained no information about the person or risks to them. Similarly, managers could not explain how records of pressure sore assessments for a person informed their planned care.
- Some people's care plans were not always clear about what care and support staff were to provide when at which care visit when they were to visit a person several times in a day. Some records of daily care were not always clear about what care was provided to a person during a care visit and the person's well-being at that time.
- The registered manager was not able to provide without undue delay some records of people's care when requested as part of this inspection.

These issues indicated systems were either not in place or robust enough to demonstrate safety, quality and the management of service records were effectively managed. This placed people at risk of harm. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We discussed these issues with the registered manager so they could address them. During our inspection visits we saw the provider was taking action to archive or dispose of assorted care records. We signposted the management team to guidance on retention requirements for documents such medicines support records so they could implement good practice regarding the handling of records related to the management of the service.
- We also saw some people's care plans provided personalised information about a person and what care they needed staff to provide and when. Some daily care records documented of how a person was when staff visited and what care and support provided they received.

● The provider conducted a series of checks to monitor the quality of the service. These included regular telephone calls to people and their relatives, care plan reviews and unannounced checks and observations of care staff in people's homes.
● Records of these checks indicated people and relatives gave positive feedback about the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● We received mixed feedback from staff about the culture of the service. Some commented there was a lack of focus on ensuring staff provided good care. Other staff we spoke with felt they were supported and staff morale was good. One worker said, "We're quite close… We are a team, a family right now." Staff said the office staff or managers were available to them.
● People and relatives said they found staff "kind and caring" and they received a good service. Relatives thought staff understood their family members' needs. One commented, "It's a good service and we're not unhappy."

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
● The provider had recently employed a quality assurance manager. They had developed new processes for collecting and monitoring information on how the service was performing so they could make improvements. For example, identifying care workers who were not recording their care visits appropriately or attending visits as scheduled. The quality assurance manager said they felt listened to and supported by the registered manager. This indicated a commitment to learning and improving the service.
● People and relatives told us they could raise issues with the provider and staff were responsive to them.
● The registered manager was aware of their duty of candour responsibilities, acted when things had gone wrong and worked to improve the service. We saw they had used staff supervision sessions to monitor staff competencies, such as their understanding of adult safeguarding and whistleblowing practice.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and relatives were involved in their care service. People told us they had no problems contacting the provider's office when they needed to.
● The registered manager held monthly team meetings to discuss the running of the service. Meeting records indicated that issues discussed included staff recruitment, training, maintaining people's confidentiality and improving the use of the ECMS.
● Managers sent staff periodic newsletters to keep them informed about developments. These most recently highlighted concerns about staff not using the ECMS properly, pressure care awareness and COVID-19 awareness.

Working in partnership with others
● The service worked in partnership with other health and social care agencies, such as social workers and GPs. This helped people to receive joined-up care to meet their needs.

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 The registered person did not always ensure care and treatment was provided in a safe way for service users Regulation 12(1)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person was not always effectively operating systems and processes to assess, monitor and improve the quality and safety of the services provided in carrying on the regulated activity Regulation 17(1)