Ricco Care Ltd

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Inspection report

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Date of inspection visit:
23 September 2020

Date of publication:
19 November 2020

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
RICCO Care Limited is a domiciliary care agency that provides personal care to people in their own homes. At the time of the inspection the provider told us there were two people receiving personal care. The local authority had recently removed eight contracts from the agency because of concerns about the care being delivered.

People's experience of using this service and what we found

People were not safeguarded from the risk of abuse because the provider could not demonstrate they had acted to protect people from harm, and they had not investigated concerns appropriately. Staff were aware of signs of abuse although some, including the registered manager, had not acted to safeguard people when these had been identified.

Risks had not been safely managed. Actions to reduce risks had not been considered and care plans were not always reflective of people's support needs. This placed people at risk of receiving unsafe or inappropriate care.

People were not protected because records did not reflect safe administration and recording of medicines and staff competency was not being checked appropriately, meaning mistakes could be made and not identified.

Staff recruitment files, when available, could not demonstrate staff had been recruited safely. The recruitment files we looked at were incomplete. We could not be assured the service employed fit and proper persons. This meant people could be at risk of receiving unsafe care.

We found widespread shortfalls in the way the service was managed. The provider could not demonstrate the safe and effective running of the service. Audits, when available, had not identified poor practice, meaning they were ineffective. The provider had failed to notify appropriate agencies, including CQC of safeguarding concerns until directed. There was no evidence that people had been consulted about the care they received. Records were not always available for review. We were not confident that the information we received was accurate as the registered manager, the staff we spoke with and people who used the service often shared different information about the service they received. This meant we could not be confident people received a safe service.

People who used RICCO Care Limited did not receive a safe or well led service. Although people who currently used the service told us they felt safe while receiving personal care, the provider was unable to demonstrate the safe and effective running of the service.

Rating at last inspection

The last rating for this service was good (published 25 April 2019).

Why we inspected
We had received concerns from social care professionals that suggested safeguarding concerns had not been adequately investigated and the processes required to keep people safe were not always robust. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. Our findings reflected the concerns shared with us.

We reviewed the information we held about the service. We did not inspect the key questions of effective, caring and responsive which are rated requires improvement. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for this service has changed from good to inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for RICCO Care Limited 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 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.

We have identified breaches in relation to the recruitment and fitness of staff, safe care and treatment, staffing, safeguarding people from abuse and in the governance of the service at this inspection. We are currently taking enforcement action against the provider.

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
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 six 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? The service was not safe.	**Inadequate**
Is the service well-led? The service was not well led.	**Inadequate**

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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 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.

The service had a manager registered with the Care Quality Commission. This person was also the provider. This means that they are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 36 hours' notice of the inspection. This was because we needed to be sure that the provider/registered manager would be in the office to support the inspection.

Inspection activity started on 23 September 2020 and ended on 24 September 2020. We visited the office location on 23 September 2020.

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 professionals who worked with the service. 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 one person who used the service and one person's relative about their experience of the care provided. We spoke with three members of staff (two support staff and a care coordinator) and the provider.

We reviewed a range of records. These included two people's care records and four staff files in relation to recruitment and staff supervision. We also looked at variety of records relating to the management of the service. Some of the information requested was no longer available because it had been destroyed by the provider.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

This service was previously rated as good in this outcome area. We found it has now deteriorated to inadequate. People were not safe and were at risk of avoidable harm. Some regulations were not met.

Systems and processes to safeguard people from the risk of abuse

- People were not safeguarded from the risk of abuse because the provider could not demonstrate they had acted to protect people from harm and had not investigated concerns appropriately.
- Staff told us they were aware of signs of abuse and that allegations of abuse should be referred to the provider without delay. However, one senior staff member had shared concerns with the provider on the day of an incident and the provider had not referred it to the local authority as was their responsibility. This meant that important information required to keep a person safe had not been passed on to enable the local authority to put safeguards in place to keep the person safe.
- One person who used the service was not receiving the care that was planned for them and payed for by the local authority. There was no evidence to reflect a review had taken place relating to this person's needs. The lack of staff support, that contradicts the person's care plan meant they could be at risk of having their care needs neglected.
- Where an incident had been reported to the local authority safeguarding team (by an external agency) the provider had failed to support the process by destroying evidence needed to demonstrate they had taken appropriate action against the staff members who caused the harm. Given the safeguarding investigation had not been closed by the local authority, the destruction of evidence had jeopardised the investigation and any subsequent action.
- One person told us they paid for their own care. They told us how many staff supported them. When we saw how the provider broke down the costs for this person, we found a discrepancy. For example, their care plan said they were supported by one staff member twice a day and then two staff twice a day. The breakdown of their charges reflected they had two staff for four calls a day. This meant the person may not be paying the correct amount for their care.

This was a breach of regulation 13, Safeguarding service users from abuse and improper treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Both people who used the service spoke positively about the staff team, saying they were always kind and polite. Although people told us that sometimes the language barrier could be a problem, they felt safe and reassured when receiving personal care.
- One person told us staff told them 'never to worry about anything' and went on to say, "They try their best for everything."

Using medicines safely

- We were advised about concerns in relation to the safe management of medicines prior to the inspection by the local authority.

● One person had been given the wrong medicine. The provider could not demonstrate that action had been taken to reduce the risks following this incident meaning there was a likelihood the incident could happen again, thus placing people at risk of harm.
● Due to the lack of information provided to us on the day of our site visit, the provider could not demonstrate staff supported people to receive medicines safely and this placed people who used the service at risk of harm.
● Two staff members told us they administered medicines and had received training to do so. The training had not equipped staff to recognise that they were not safely recording the administration of medicines and creams as prescribed by the health care professional. The senior staff member, who told us they were responsible for checking staff competency, had not identified they were not recording the administration of creams or that the recording sheets were inadequate. This meant staff could not demonstrate they had administered medicines safely.
● The registered manager had audited administration records and had not identified the audits were not effective to demonstrate safe medicine practice. For example, people told us staff administered their prescribed creams, but this had not been recorded on the medication administration record (MAR). This meant that we could not be assured these prescribed creams had been administered to people as needed.
● The care coordinator told us they were looking to access more training in the safe management of medicines to enable them to be more effective and said, "Medicines administration records have room for improvement."
● The relative of one person who used the service said staff did not support their family member with the administration of medicines. The other person said they supported them effectively.

Assessing risk, safety monitoring and management
● There was a discrepancy as to when care plans and risk assessments were implemented. One relative told us they had been completed two weeks ago (after the local authority had input with the service) and that they had been involved in their development. This meant that, at the time of the start of the service, there had been no initial assessment for this person who had needed rehabilitation and support. Social care professionals had told us they had been concerned about the lack of care plans, suggesting people were being supported without a plan or risk assessment of their care needs.
● When risks had been identified there was nothing documented to show how staff should mitigate these risks. For example, both people who used the service were assessed as being at high risk of falls. There was no action plan mitigate this risk. This meant staff may have placed people at risk of harm while delivering personal care as they were not instructed how to provide care safely.
● We did not see a moving and handling assessment on the care file of one person, despite their care plan stating, 'Lift [their] legs into bed, put [them] in and out of bed.' The person confirmed that staff supported them to be moved in and out of bed. The lack of detail as to how to support the person safely placed them at risk of harm.
● Another person had required support to be moved in bed according to their care plan. Their care plan reflected this, however the person's relative said that staff no longer helped them to do this. There was no rationale or assessment to support this change meaning the person could be at risk of not receiving safe support. There had been no review of this person's care meaning the changes could have put the person at risk of harm.
● A recent call made to the provider from CQC, to see how they were managing during the pandemic, identified that they 'needed support' to deliver safe care to people who used the service at the time. This outcome related to concerns in respect of medication not being recorded at the point of being given. We also had concerns that risk assessments were not robust enough to capture risks, so staff were fully informed of how to mitigate risk. For example, how to reduce the risk of falls. Our findings on the day of our site visit reflected these outcomes.

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

Staffing and recruitment

● The provider told us they employed four staff. We were shown their recruitment files at the time of the inspection and we noted the staff names.

● The current working rota reflected that four staff worked together to support the two people who received a service. However, the service's training record indicated that there was another staff member working for the provider. There was a discrepancy as to whether this staff member had left or was isolating following their return from holiday. One person who used the service named additional staff who visited them. We spoke with the other person who used the service, who was unable to tell us the names of staff who supported them. The registered manager told us they had no other staff records. This meant staff had worked for the agency but had had their information destroyed. The registered manager could not therefore demonstrate a safe recruitment process, or that fit and proper persons were employed.

● Of the four staff files we saw there was essential information missing. Three files were missing a reference. No files contained evidence that the staff member was fit for the job they were employed to carry out. The provider told us they had recently requested outstanding information to support the recruitment process. However, these staff were currently working with vulnerable people placing people at possible risk of harm.

This was a breach of Regulation 19, Fit and proper persons employed, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● Records showed a person had sustained an accident and some of the practice that had led to the harm was shared with staff in order to learn lessons from it. Although the update did not cover all issues of concern relating to the incident the provider could demonstrate that some learning had taken place.

● The provider told us how they were making improvements following input from the local authority. For example, they told us how they were now auditing medicines administration records. Although the audits were ineffective, they had identified a willingness to make changes to improve the service.

● The provider told us that they were looking to external care provider services to assist them to develop their own policies and procedures to improve the service they provided. They told us they had done this after recognising shortfalls in their current practices and processes.

Preventing and controlling infection

● Staff told us they had recently received training in relation to infection, prevention and control. They said they had been shown how to effectively wash their hands and use personal protective equipment when supporting people. People who used the service confirmed staff wore gloves, aprons and masks. These practices helped to mitigate the risk of cross infection.

● We observed hand gels were located throughout the office and staff had access to handwashing facilities. We also observed senior staff members maintained social distance during the inspection.

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.

This outcome area was previously rated as good. We have now rated this service as 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. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The service was not well led or managed. Information required to ensure the safe operation of the service was not available or had only been produced following input from the local authority who had shared concerns about the management of the agency.
- The provider did not send us all the required information in a timely manner. For example, we asked for contact details of people who used the service and staff prior to the inspection. This was not provided prior to our inspection and was hand written for us at the time of the inspection visit.
- The provider is required by law to inform us of incidents that have occurred in relation to the service provided. They had failed to do so until prompted by us. For example, a medication error had led to harm had not been notified to us and an incident where a person had been harm after staff had not acted to keep them safe. This meant you could not demonstrate you were aware of your regulatory responsibility and thus as a result your fitness to provide a safe service.
- Some records were missing essential information and some records were inaccurate or illegible on the day of the inspection. This meant the provider could not demonstrate the safe operation of the service provided. For example, the staff files did not reflect a safe process for recruiting and inducting staff and care plans did not accurately reflect care delivered.

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

- Although people who currently used the service told us they felt comfortable with the support they received and were satisfied with the service they received, we found that one of the two care packages was being delivered by a family member and not the staff who visited three times a day. This change had not triggered a reassessment of the person's needs and meant the service was being paid for by the funding authority and was not being delivered.

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

- We saw evidence that when things had gone wrong the provider had contacted the person receiving the care and apologised formally to them. However, they did not always contact authorities to share concerns and work openly with agencies to investigate and improve services.
- Staff records for staff no longer working for the service had been destroyed. Service user care plans for

people who no longer used the service had been destroyed. Given the timescales of the destruction of the documents the provider had not acted within national record keeping guidelines. By destroying records, the provider could not demonstrate they had acted appropriately to demonstrate care and support.
● We saw audits had been implemented recently to monitor the effectiveness and safety of medicines management. We saw these audits had not picked up the issues we found meaning they were ineffective. When we shared our feedback with the provider and the care coordinator, they had not recognised they were not effective. This meant that the provider was not effectively monitoring the safety of the service.

This is a breach of Regulation 17(1) good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care
● We saw the care file of a person who had had a fall and their records did not reflect their risks had been reviewed or reassessed. This meant the provider had not reduced the likelihood of reoccurrence and so could not demonstrate they had learnt from the incident or improved care as a result.
● The registered manager and the care coordinator told us how they had now sought to work with outside agencies to provide accredited training and receive overall service support. They had identified that this would help them to improve the quality of their service for the future.

Working in partnership with others
● The provider told us that there had been a delay in them sharing information with the local authority or providing information in a timely manner and this was one of the reasons why their support contracts with the local authority were withdrawn. Social care professionals confirmed this had been an issue. This meant the provider was not working effectively with partner agencies to ensure a good service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People fed back that staff were keen to support them in ways they preferred. A member of staff told us they asked the people they supported if 'everything was ok' and this demonstrated they were satisfied with the service provided. There was no evidence that this was done at a management level, meaning they did not know if people were satisfied with the service that staff were providing.
● One relative told us they had been consulted in developing their family member's care plan, although not at the start of the service delivery. This meant that details about people and their preferences and equality characteristics had not been identified. Staff could therefore not deliver a service to meet people's individual needs.