Tabitha Homebase Care Limited

Tabitha Homecare Ltd

Inspection report

1 Birmingham Road
Great Barr
Birmingham
West Midlands
B43 6NW

Tel: 01213575913
Website: www.tabithahomecare.co.uk

Date of inspection visit:
14 March 2023
15 March 2023

Date of publication:
06 November 2023

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
Tabitha Homecare Limited is a domiciliary care service providing personal care to people living in their own homes. At the time of our inspection there were 7 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
Governance systems in place were not effective. At the last inspection we found the provider's oversight of the service had not identified the shortfalls we found. At this inspection this continued to be the same, and these were repeated concerns over the 4 previous inspections.

Care plans and risk assessments continued to lack robust and clear guidance, with incorrect or conflicting information. Risks to people were not thoroughly assessed and failed to inform staff on the actions they should take to keep people safe.

There were unsafe recruitment at the last inspection, because no new staff had been employed, at this inspection we were unable to ascertain if robust systems were now established.

Some improvements to staff training had taken place. Staff we spoke with were aware of their responsibilities to keep people safe. Most people told us staff were caring and kind.

People were 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; the policies and systems in the service supported this practice.

At the last inspection we found the provider's oversight of the service had not identified the shortfalls we found during the inspection process as part of their audits and checks. At this inspection this continued to be the same.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 24 November 2022) and there were breaches of the regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations and they had either not implemented or maintained the improvements they said they had made.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. The overall rating for the service has remained Inadequate. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvements. Please see safe, effective, caring, responsive and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Tabitha Homecare on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified repeated breaches in relation to; Regulation 12 – Safe care and treatment, and Regulation 17 – Good governance at this inspection.

We issued a notice of proposal to cancel the providers registration.
Please see the action we have taken detailed at the back of the report.

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 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 provider's oversight of the service had not identified some of the shortfalls we found during the inspection process as part of their audits and checks.

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.

Tabitha Homecare Ltd

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 team comprised of two inspectors who carried out the site visit on 14 March 2023. One inspector returned on 15 March 2023 to complete the site visit.

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

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 24 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.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. The provider did not complete the required Provider Information Return. This is information providers are required to send us with key information about the service, what it does well and improvements they plan to make. We took this into account in making our judgements in this report. We also contacted commissioners of care services for

their feedback about the service. We used all of this information to plan our inspection.

During the inspection
We spoke with 4 people who used the service and 3 relatives. We also spoke with 3 care staff, and the registered manager who is also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed 5 care plans and a selection of medication records and risk assessments. A variety of records relating to the management of the service, including the training matrix, audits and policies and procedures were reviewed.

Inadequate

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 inadequate. At this inspection the rating has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At the last inspection the provider was in breach of regulation 12, risk assessments did not contain clear guidance for staff to follow to keep people safe. At this inspection the required improvements had not been fully implemented, and the provider remained in breach of Regulation 12.

- Risks to people were not always effectively managed. For example, where a risk of sore skin was identified there was no guidance for staff to follow regarding what to look for, what action to take or recording of skin integrity.
- There was a change in a person's mobility, they were finding it difficult to get in and out of the bath. Staff were supporting the person to do this but no risk assessment had been completed, to identify and mitigate any risks to the person and the staff member's safety.
- Where bed rails were in place, there was no guidance about the safe positioning of the rails, the safe height of rail to mattress, or records of any safety checks.
- Staff were preparing and leaving hot drinks in a flask for a person, there was no risk assessment in place to assess and mitigate any risks to the person of scalding.
- Where risks to people were known due to their diagnosed health conditions, for example, epilepsy, cerebral palsy, and Alzheimer's disease, there were no care plans to guide staff on how to support people safely. The lack of guidance and information for staff to follow placed people at an increased risk of harm.
- People did not always receive their calls on time, or received shortened calls. Some people had 2 staff rostered to support them, and only 1 staff attended the call. This placed people at an increased risk of harm.

The provider failed to ensure care and treatment was provided in a safe way. They did not ensure all risks relating to the safety and welfare of people using the service were consistently assessed, recorded and managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At the last inspection the provider was in breach of regulation 12, medicines were not always administered safely. At this inspection we found the required improvements had not been made.

- Medicine systems were not safe and effective. A medicine was not administered as prescribed as it should have been given every 3 days (72hours). In a week's period for March 2023, the medicine was given at 48 hours and then 24 hours, and then 96 hours. The provider failed to have a safe system to check the medicine

was given as prescribed.
● Where people received their medicines through a Percutaneous Endoscopic Gastrostomy (PEG), (A PEG allows food, fluid and medicines to be passed directly into your stomach through a tube). There was no guidance for staff to follow to say how medicines should be safely administered, no guidance about care of the PEG site that staff were attending to, and no competency checks on staff's ability to carry out the task. This placed the person at risk of harm.
● There was a lack of guidance on how and where staff should apply prescribed creams. People's care plans stated, 'carers to apply the creams according to how it is prescribed'. There was no information about how or where creams should be applied. This placed people at risk of deterioration in their skin condition or skin integrity because they were not having their prescribed creams applied as per their prescription.

Medicines management was not robust enough to demonstrate that medicines were managed safely at all times. This placed people at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At the last inspection the provider was found to be in breach of regulation 19 as they had not always completed checks on staff to ensure they were safe to work with vulnerable people. At this inspection the provider was no longer in breach of Regulation 19.

● At our last inspection safe recruitment practices were not always followed. Staff had been employed without references and had incomplete work histories on their application form.
● At this inspection the staff members with concerns about their employment records, no longer worked at the service. The provider was in the process of employing 1 staff member and checks were still in process.
● There was a reduction in care packages and staff employed. There was enough staff employed to cover the care packages, although the staff allocation to the care packages were not always managed effectively.

Systems and processes to safeguard people from the risk of abuse
● At our last inspection we found the provider's systems to recognise and take action, on poor practice were not always effective. For example, where calls were late, shortened or 1 staff member was in attendance instead of 2, these shortfalls had not been identified by the provider's own systems. Therefore, no actions had been taken to ensure this did not occur again and reduce the potential harm to people. This remained a concern at this inspection, there was no evidence improvements had been made.
● We received mixed feedback from people, their relatives and friends about their experience. Some people were very satisfied. One person told us, " Yes I feel safe with the staff." Two relatives told us they were not happy with their family members care and were in discussion about this at the time of this inspection.
● We had shared some recent concerns with the local authority regarding the quality of care calls, and the provider was asked to investigate these. At the time of this inspection, we were told the concerns had been substantiated.
● Staff had received safeguarding training. Staff told us if they saw poor practice, they would report it to the registered manager. A staff member told us " If I had any concerns I would let the office know and [provider's name] and they would deal with it."

Learning lessons when things go wrong
● There was a process in to record accidents, and incidents, including incidents relating to the quality of calls. However, this was not effective. The providers own systems had not identified the concerns we found during our inspection.

Requires Improvement

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.

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People's needs had been assessed at the time the service started, in line with legislation and guidance, but assessments were not always robust. We found that not all care and health needs identified, had plans in place to ensure those needs were met safely and effectively. For example, health and needs in relation to cerebral palsy and epilepsy. Also, when peoples' needs or choices changed, this was not always accurately reflected in people's care plans.
- People's communication needs were not always reflected. This meant we could not be assured staff had enough information to support the person in a person-centred way.
- Despite gaps in care records staff we spoke with understood people's support needs and how to provide their care.
- People's protected characteristics, as identified in the Equality Act 2010, were considered as part of their assessments. This included needs in relation to age, culture, religion, ethnicity and disability.

Staff support: induction, training, skills and experience

- At our last inspection staff did not have the relevant training to carry out specific care tasks. At this inspection we found some improvements had been made. For example, staff had completed PEG feed training. However, no competency assessments had not been completed to assess staff have implemented and maintained the required knowledge and skills to support people safely.
- Spot checks of staff practice were carried out infrequently and failed to identify the shortfalls we found in relation to the quality of care calls and potential risks to people.
- Staff told us they had completed a range of online training and they had also received some face to face moving and handling training.

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 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.

● Care records detailed when a person could make day to day decisions about their care and support.
● Where a person lacked capacity, there was no process to clarify if a deputy had been appointed by the Court of Protection. A deputy is a person who can make decisions for the person.
● Staff told us they sought people's consent before providing care.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Care records were not always clear when people were receiving support from other health care professionals that impact on people's day to day care. For example, one person had regular district nurse input but the registered manager told us this was not taking place. This meant important information about the person's medical condition which had potential to impact on their care and support needs, was unknown.
● Staff told us they recognised when a person was unwell and required additional support such as a GP or ambulance. A staff member told us, " I would call an ambulance if needed, and then let the office know."

Supporting people to eat and drink enough to maintain a balanced diet
● Not all people we spoke with required support with meal preparation or assistance to eat.
● People's dietary needs were not always clear for staff to follow. For example, where staff were preparing or reheating food, there was not always clear instructions about this for staff to follow.

Requires Improvement

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.

At our last inspection, we rated this key question requires improvement. At this inspection the rating remains 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

- We received some mixed feedback from people, about their care calls. Some people remained very happy with the care received and spoke highly of the staff. Some people and their relatives were not happy with their care calls.
- One person told us, "I am happy with everything, the staff are very good. I really have no concerns. " A relative told us, they had spoken with the provider about staff not always being pleasant and polite to their relative when supporting them with their care.
- People's care plans included some information about their preference's cultural needs and personal histories. This helped staff to get to know people, so they could support people in a way they preferred.
- Staff we spoke with understood peoples' support needs. A staff member told us," I have got to know the people I support, and I enjoy the conversations we have."

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

- Where people were not able to express their views verbally, care plans did not have clear information about people's communication needs. This information which would guide staff in how to involve people in decisions about their care.
- Most people told us staff would ask them about their care and how they wanted to be cared for. Records showed that reviews of people's care plan did take place, and the person was asked for feedback. However, where comments were made, it was not always clear to see these had been acted on. For example, some people had requested a change to care calls times, but records showed these had not been acted on.

Respecting and promoting people's privacy, dignity and independence

- A person told us, " I like my regular staff member, they know me and encourage me to do what I can, I am still quiet independent."
- Staff spoke about people respectfully and shared examples of how they had got to know people, and their individual preferences.
- Staff told us the respected people's privacy and dignity. A staff member told us, " I always make sure the curtains are closed and the door is shut. I use a towel to cover the person, and I talk to them about what I am doing."

Requires Improvement

Is the service responsive?

Our findings

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

At our last comprehensive inspection, we rated this key question requires improvement. At this inspection the rating remains 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; Supporting people to develop and maintain relationships to avoid social isolation; Support to follow interests and to take part in activities that are socially and culturally relevant to them

- People's personalised care was impacted by the inconsistency in their care calls. We reviewed the records of recent care calls and identified shortened calls and calls earlier or later than planned. A person who needs help to get in and out of bed told us they didn't want their evening call to be too early because they would be in bed too long. A review of recent records showed that all but one call had been before the time they had requested. This showed care calls had not been responsive to their needs.
- Care plans lacked information about specific health and care needs and had not been updated with changes in people's needs. For example, there was no care plan in place for people who had epilepsy which can cause seizures or unusual sensation and behaviour. A person's mobility had changed and they needed more assistance from staff to keep them safe, their care plan was not updated to reflect this.
- People's care plans gave some information about their hobbies and interests. This was available for staff to refer to so as they could have conversations with people.

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 their can understand it. It also says that people should get the support they need in relation to communication.

- People's communication needs had been assessed and were documented in their plans of care. However, where a person was unable to communicate verbally, there was no information about how staff could support the person with their communication, for example, observe for specific facial expression or body language.
- The provider told us they were able to produce information in an accessible format if needed.

Improving care quality in response to complaints or concerns

- The provider had a complaints policy and procedure. The system for recording a concern or complaint and the outcome had not been kept up to date, so it was not clear how the provider had investigated concerns raised and reached an outcome.
- People and relatives had mixed views about how concerns and complaints would be dealt with by the provider. One person told us, " Things are okay at the moment, if there are any problems then [relatives name] would contact the office for me." Some relatives told us they were not satisfied with how concerns brought to the providers attention had been dealt with and discussions about this was taking place at the

time of the inspection.

End of life care and support

- At the time of the inspection, no one supported by the service was receiving end of life care.

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 our last inspection we rated this key question inadequate. At this inspection the rating has remained 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; 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

At our last inspection the provider was found to be in breach of Regulation 17, as the quality assurance systems in place were not were not effective. Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17 good governance.

- This was the fifth consecutive inspection where the provider has failed to meet the regulations. There have been repeated breaches in relation to safe care and treatment and good governance across all 5 inspections. The provider systems and processes had not enabled them to identify the concerns found during the inspection.
- The providers systems and processes had not enabled them to identify medicines were not always managed safely. For example, medicines were not always given as directed by the prescriber, and documentation in relation to medicines were not always accurate.
- The provider's systems and processes had not enabled them to recognise the oversight and scrutiny of safeguarding incidents and complaints were not always effective. This meant there were missed opportunities to reduce the risk of further potential harm to people.
- The provider's systems to monitor the quality of risk assessments and care plans had not been effective in identifying they lacked detail and were not in place regarding specific care needs and health conditions.
- The provider's system to audit the quality of care calls was ineffective and failed to identify the shortfalls we found. This included late calls, staff not attending calls, only one staff attending a two staff call, calls not within the scheduled time, and shortened calls. This meant people were at increased risk of unsafe care.
- The provider had a risk log to capture areas of improvement they were working on. However, they had failed to identify many of the issues we identified during the inspection.
- The provider failed to complete their annual Provider Information Return (PIR). The purpose of the PIR is to help us identify areas to explore in more detail as part of our continuous monitoring of a service. We had requested this information twice from the provider.

We found no evidence that people had been harmed however, systems had failed to ensure effective monitoring of the quality of the service. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Continuous learning and improving care

● The provider told us it had been a difficult time for the company following COVID-19. They told us they felt they were making steady progress.

● The provider cooperated with the inspection process. Despite a drastic reduction in care packages and supporting people with less complex needs, the improvements needed had not been made.

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

● We received mixed feedback from people and their relatives. Some people were not happy with their care and some people were happy with the care provided. A relative told us, "We are not happy with things. We don't know what they are doing during a care call, and not sure how long they are staying at [person's name] call for. I have raised concerns, but things are not improving. Another person told us, " Things are okay, the staff are quite good really, I have no complaints."

● We saw that people were asked for their feedback and this was recorded in their care records under 'service reviews'. However, when an issue was raised, it was unclear what action had been taken by the provider. For example, one person raised they wanted the time of their evening call to not be before 9pm. There were no follow up actions to show this feedback had been addressed and when we checked the call records for a number of weeks for this person, only one call had taken place as requested.

● Staff were positive about the support they received to carry out their role. They told us the registered manager and deputy were very approachable and supportive.

Working in partnership with others

● The provider told us they worked with healthcare professionals and the local authority.

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 At the last inspection the provider was in breach of regulation 12, risk assessments did not contain clear guidance for staff to follow to keep people safe. At this inspection the required improvements had not been fully implemented, and the provider remained in breach of Regulation 12.

The enforcement action we took:

NOD to remove providers registration

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance At our last inspection the provider was found to be in breach of Regulation 17, as the quality assurance systems in place were not were not effective. Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17 good governance.

The enforcement action we took:

NOD to remove registration