Tabitha Homebase Care Limited

Tabitha Homecare Ltd

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service

Tabitha Homecare Ltd is a home care agency providing personal care to 65 people at the time of the inspection. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

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

Where safeguarding incidents had occurred, the provider had not always shared this information with external agencies. Risks to people's safety had not always been assessed accurately. Recruitment procedures did not consistently ensure staff were safe to work. Medicine records showed medicines were not always given as prescribed. There were sufficient numbers of staff to support people.

The providers systems to monitor and improve the quality of care provided were ineffective and did not identify where improvements were needed. Where improvements had been identified, these were not consistently acted upon. People and staff were given opportunity to feedback on the quality of the care provided.

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 (Report published 01 April 2021) and there were four breaches of regulation. At this inspection enough improvement had not been made/ sustained and the provider was still in breach of regulations.

Why we inspected

We carried out an announced comprehensive inspection of this service on 06 January 2021. Breaches of legal requirements were found. The provider failed to complete an action plan after the last inspection to show what they would do and by when to improve.

We undertook this focused inspection to check they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.
The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service

remains 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 Tabitha Homecare Ltd 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 recruitment, risk assessments, acting on safeguarding concerns and 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 continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service remains 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 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 Care Act 2014.

Inspection team
The inspection was completed by two inspectors and an assistant 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.

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 19 April 2021 and ended on 26 April 2021. We visited the office location on 20 April 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection-
We spoke on the telephone to 13 people and six members of staff. We spoke in person with the registered manager. We reviewed a range of records. This included four people's care records and one medication record. We looked at three 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.

After the inspection –
We continued to seek clarification from the provider to validate evidence found. We looked at incident reports, one further medication record and policies relating to COVID-19.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse
At the last inspection, the provider was found to be in breach of Regulation 13 as they had not taken timely action in response to safeguarding concerns. At this inspection we found the required improvements had not been made and the provider remained in breach of regulation.

● The provider informed us of an incident that had occurred which potentially left a person at risk of harm. This information had not been shared with the relevant external agencies so that the concern could be investigated, and action taken to ensure people's safety.

This is a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they understood their responsibilities in reporting any concerns of abuse. One staff member told us, "Any concerns and I would bring this straight to the management."

Assessing risk, safety monitoring and management; Using medicines safely
At the last inspection the provider was in breach of Regulation 12 as risk assessments did not provide clear guidance for staff on how to keep people safe. At this inspection, the required improvements had not been made and the provider remained in breach of Regulation 12.

● Where risks to people's safety had been identified, action had not always been taken to keep people safe. For example, one person required equipment to support them to mobilise safely. The provider had identified this but had not put guidance in place for staff to follow while they awaited the required equipment. In addition, one person displayed behaviours that can challenge. The provider was aware of this risk, but had not risk assessed this or provided information for staff on how they could ensure the persons safety. This meant staff did not have access to the information they needed to ensure they were supporting people safely.
● In one instance the provider had not assessed the risks to a person correctly. The provider had given incorrect guidance to staff about a person's mobility and this had led to staff supporting the person in a way that did not meet their needs. We took immediate action to safeguard this person and ensure their needs were assessed accurately.
● One person received support with their medicines. Medication Administration Records (MARs) showed that this medicine had not been administered on a number of occasions in the previous two months. These

missed medicines had not been identified by the provider and so no action had been taken to ensure the person's safety.

This is a breach of Regulation 12 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 required improvements had not been made and the provider remained in breach of Regulation 19.

● One staff member was found to be working alone in people's homes without a valid Disclosure and Barring Service (DBS) check in place. A DBS check would inform the provider if a staff member had criminal convictions or had been barred from working with vulnerable adults. The provider had not assessed the risk of this staff member working without the relevant checks being completed.

This is a breach of Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider informed us that this staff member no longer worked at the service.

● People told us they received their support on time from a consistent team of staff. One person told us, "In the main we get the same carers, it can be different of a weekend but it's always the same 6-7 staff. They do arrive on time." Staff confirmed they had enough time to spend with people and did not feel rushed in their role.

Preventing and controlling infection
● People told us that staff wore personal protective equipment (PPE) when supporting them. One person told us, "Yes staff always wear the PPE. I have seen them wearing it".
● The provider had taken action since the last inspection to improve infection control measures and we saw there were now places for staff in the office to dispose of their PPE. However, we saw that staff members visiting the office were not consistently wearing masks and social distancing. The provider's policy on COVID-19 had not considered measures to be implemented to ensure safety for staff and visitors to the office.

Learning lessons when things go wrong
● Although the provider displayed a willingness to learn lessons where things go wrong, they had not been able to make sufficient improvements to meet regulations. This means that lessons from the previous inspection had not yet led to improvements in the quality of 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 the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At the last inspection, the provider was found to be in breach of Regulation 17 as the quality assurance systems in place were not effective. At this inspection, the required improvements had not been made and the provider remained in breach of Regulation 17.

- The provider had implemented audits to monitor the tasks that had been completed by staff when supporting people. However, these audits had not identified where some visits were significantly late or cut short. This meant that some visits may not have been completed as required but had not been identified or acted upon by the provider.
- Systems to monitor the safe administration of medicines had not been implemented. This meant that the provider had not identified that some people had not received their medicines as required or taken any action to reduce the risk of further errors in future.
- The provider's systems to monitor the quality of care plans had not identified where records held incorrect information about people, or that key risks to people's safety had not been assessed. For example, missing information about how to support with mobility or behaviours that can challenge.
- The provider had not taken action to ensure that staff were fit and proper to provide care. Systems in place for monitoring the service had not identified that risk assessments were not in place for staff who had not completed a DBS check.

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

- Following the inspection, the provider sent us an action plan detailing how they intend to address the concerns raised at this inspection.

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; Working in partnership with others

- The provider had not met their duty of candour. Where an incident occurred, this had not been shared

with external agencies to ensure people were safe. This meant that all relevant agencies were not informed of the incident or the actions taken by the provider to keep people safe.

Continuous learning and improving care

● The provider had made some improvements to the recruitment procedures since the last inspection. However, they had not made improvements in other areas identified at the last inspection. This means that although some improvements had been made, the provider had not ensured that the care provided was improved in a timely way where areas for improvement had been identified.

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

● People told us they were asked for their feedback on the care they received. One person told us, "I have had a call from a senior carer before asking if I was happy with everything. They have done that three or four times now." People told us that action was taken in response to their feedback.
● Staff told us they took part in meetings and supervisions in which they could discuss any issues or feedback with their manager directly. One staff member told us, "I get time with the manager so I can talk to them if needed." Staff gave us examples of where the provider had acted on their feedback, including changing the length of people's visits to give staff time with people.