Servicescale Limited

inTouch Home Care

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?	**Inadequate**

Summary of findings

Overall summary

About the service
in Touch is a domiciliary care agency providing personal care to people in their own homes. The service was supporting 88 people with personal care in their own homes at the time of our inspection.

People's experience of using this service
Systems for identifying and managing organisational risk were not effective and information to support performance monitoring was not always reliable. Staffing issues meant senior staff had been delivering care calls and were unable to effectively carry out their roles and responsibilities to manage service delivery. Whilst some people were positive about the care provided, over half the people spoken with raised concerns about missed and late calls and inconsistent staff who lacked the knowledge and understanding to meet their needs. Not everyone had confidence in the complaints process because issues of concern continued despite complaints being raised.

Safeguarding systems were not sufficient to ensure risks associated with people's care were promptly identified and managed to reduce the risk of people coming to harm. Systems in place for the oversight of safeguarding incidents did not demonstrate they had been managed effectively and risks to people had been mitigated.

Some areas for improvement of the service had been identified but actions to implement changes were still in progress at the time of our visit.

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

Why we inspected
The inspection was prompted by concerns we had received about missed and late care calls, inconsistency in standards of care due to high staff turnover, failure to address concerns and complaints and the overall governance of the service. As a result, a decision was made for us to inspect and examine those risks. We undertook a focused inspection to review the key questions of safe and well-led only.

The overall rating for the service has deteriorated to requires improvement. This is based on the findings at this inspection.

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 two breaches of the regulations in relation to the safety of people's care and governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

inTouch Home Care

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 team consisted of six inspectors and an assistant inspector. Two inspectors visited the provider's offices and four inspectors and the assistant inspector supported the inspection by speaking with people, relatives and staff by email and telephone.

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 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.

Notice of inspection
This inspection was announced. We announced the inspection five days in advance to ensure the registered manager would be available to participate in the inspection process, to make arrangements for information to be shared with the commission prior to the site visit and so infection control processes and social distancing arrangements could be agreed.

Inspection activity started on 12 August 2020 and ended on 21 August 2020. We visited the office location on 17 August 2020.

What we did before the inspection
We reviewed information we had received about the service since the last inspection and the information we had requested when the inspection was announced. This included reviewing recurrent themes of concerns

to plan our inspection. We sought feedback from the local authority who commission care packages with the service. We spoke with 18 people and 19 relatives by telephone. We had contact with nine care staff by telephone and email.

The provider had completed a provider information return in January 2020. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection
We spoke with the provider's quality and compliance manager, the registered manager and two community assessors. We reviewed aspects of seven people's care plans, associated daily care records, staff recruitment and training records and the service's records of investigations into recent complaints and safeguarding incidents. We looked at a variety of records related to quality assurance at the service.

After the inspection
We reviewed the additional documentation we had requested from the registered manager during the site visit. We continued to seek clarification from the provider to validate evidence found.

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 the last inspection this key question was rated as good. At this inspection the rating has deteriorated to 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; Systems and processes to safeguard people from the risk of abuse

• Safeguarding systems were not sufficient to ensure risks associated with people's care were promptly identified and managed to reduce the risk of people coming to harm.

• Care plans contained some information about people's risks but were not always sufficiently detailed to support staff in minimising those risks. For example, records for a person with a catheter did not contain clear instructions for staff to ensure they managed the person's personal care safely. One staff member had stepped on the catheter tube which had resulted in the person seeking medical attention.

• One person managed their own catheter, but daily records indicated staff sometimes assisted the person if they were unwell. There was no information in the person's care plan to inform staff how to provide this support safely.

• Risks associated with people's nutrition were not always managed to keep people safe. One person was to have a soft, bite sized diet where the food could be broken down or mashed with a fork. We were told there was guidance about a suitable diet from Speech and Language Therapy in the person's home. The guidance was not included or referenced in the person's care plan to make sure staff read the additional information and the person received safe care. The person had been provided with slices of beef and grapes increasing the risk of them choking.

• One person lived with diabetes and managed their medication independently. The risk assessment for nutrition had been marked as 'not applicable' even though staff supported the person with breakfast. Records did not contain information about signs and symptoms associated with high or low blood sugar levels to help staff identify concerns. The quality and compliance manager agreed this information should have been included in the care plan.

• One person was at risk of skin damage. There was limited guidance within the care plan about actions and checks staff should undertake to minimise this risk.

• Staff told us they relied on care plans for information about people's healthcare needs. One staff member told us, "There is always a care plan and information there, so that you can read through if you haven't been to that client before. Another said, "I was told verbally how to care for the people on my rota."

• Care plans were not checked frequently enough by the provider to ensure the care people should receive was provided.

• One person was in receipt of 24 hour supervision and control which meant their freedom was restricted. It was recognised this could unlawfully deprive the person of their liberty, but this had not been sufficiently followed up to ensure sufficient safeguards were in place to protect the person.

• There were ongoing concerns about missed and late calls and inconsistent care staff which left people and their relatives feeling vulnerable. These ongoing concerns and poor communication demonstrated risks

were not always being effectively managed to ensure people felt safe.
• Systems in place for the oversight of safeguarding incidents did not demonstrate they had been managed effectively and risks to people had been mitigated.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. 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
• There were not always sufficient numbers of suitably qualified staff to manage calls to ensure people were supported safely and on time.
• Half the people and relatives we spoke with raised concerns about missed and/or late calls. One person told us how the late calls impacted on their diabetes as they relied on care staff to prepare their meals. Another person told us late calls impacted on managing their pain as they needed support to take their medication. They told us, "Today they came at 10:30. They are supposed to come at just about 09:00am so I had my medicines late, and I had pain." A relative explained, "No missed calls, but timings are terrible, and the office don't phone us. It can be two or three hours late for the morning call. If carers don't come, someone from the office might come instead."
• Some people told us they had support from a consistent care staff. However, other people spoke about inconsistency of care staff who did not always have the knowledge or understanding to meet their needs safely or effectively. One person told us, "I get all different carers, I don't know who to expect each day, all different faces come." A relative told us, "You can have four, five or six different ones (care staff) at the weekend. That's really not good for someone with dementia."
• Records staff completed in people's homes did not consistently record the times when staff left to demonstrate they stayed the allocated time. One staff member told us, "I am supposed to text in when I arrive and when I leave. Sometimes I do forget."
• Records in people's homes showed the times when staff arrived were not always consistent with the times arranged.
• Staff did not always complete specialist training linked to people's needs to support them in providing safe care. Some of their essential training had not been updated in line with the provider's policy.
• Staff told us things had recently improved because more staff had been recruited, they were being given regular people to visit and they did not have to pick up so many calls at late notice. Also, the provider had sub-contracted some care calls at the week-end to another care provider. One staff member told us, "There were staff shortages, probably in June and July we were being asked to do more, obviously they are continuing to recruit. It's been alright in August though."
• The provider's monitoring systems confirmed that the timing and length of visits was improving.

Using medicines safely
• There had been multiple medication errors and medicine records did not always show medicines prescribed were being offered or administered.
• The provider's medicine policy states staff needed to receive training from a medically trained person (such as a district nurse) before supporting people to use a nebuliser. This is a machine that helps people receive relief with breathing difficulties). We were advised a senior staff member based in the office had provided this training. The staff member was not medically trained.
• One person had been prescribed a medicine to be administered through a nebuliser four times a day. Records did not show the medicines had been provided consistently. We were told a health professional had changed the dose to twice a day, but this was not clearly recorded on the Medicine Administration Record (MAR) to reduce the risk of errors being made.

• The same person was prescribed a medicine which was to be given if they became very breathless. There was a handwritten amendment to the MAR which stated the medicine should only be given if the person was in a lot of pain. This amendment went against the prescribing instructions.
• Some people were prescribed paraffin based emollient creams which carry well known fire risks. The provider had devised a risk assessment for the use of such creams, but this had not been implemented at the time of our inspection visit.
• The medicine policy and procedures did not sufficiently address medicines that required additional checks to ensure staff managed these safely and effectively. The quality and compliance manager assured us this would be addressed.

Preventing and controlling infection
• The provider had reviewed their infection control policies and procedures in response to the COVID-19 pandemic. Staff had been issued with regular written reminders about the correct use of personal protective equipment (PPE) and their responsibility to always follow good infection control practices. PPE includes items such as gloves, aprons, masks and eye protection.
• We received mixed feedback regarding staff following infection control guidance in their everyday practice. Some people confirmed staff wore PPE, a typical comment being, "They (staff) have been very good with managing COVID-19. There have been no problems with PPE. They are very good with that and all the carers wash their hands as soon as they come in and use sanitizer." However, one person told us, "The staff now mostly wear face masks but sometimes they forget. They never wash their hands on arrival or going, it worries me a lot." Another said, "Some wash their hands, others don't."
• Records showed some staff had not completed infection control training in line with the provider's expectations. The quality and compliance manager told us staff had completed training specifically in relation to COVID-19. However, the training matrix showed that only 21% had completed that training.
• We saw checks were completed on care staff when supporting people in their own homes to ensure they were wearing the correct PPE. No issues had been identified during these checks.

Learning lessons when things go wrong
• Improvements made following concerns had not been effectively addressed to minimise the risk of them happening again.
• Some areas for improvement of the service had been identified but actions to implement changes were still in progress at the time of our visit.

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 this key question was rated as good. At this inspection the rating has deteriorated to 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.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.
• In August/September 2019 due to staffing challenges within the service, the provider was unable to safely support the care packages they had in place. As a result, the local authority who commissioned with the service re-allocated some of those care packages to another provider on a temporary basis.
• We received assurance from the provider that appropriate action had been taken to reduce the risk of care packages being reallocated again. This was reiterated in the PIR submitted by the provider in January 2020. The PIR stated: "We faced a situation in August and September 2019 which was unprecedented. We have since invested a great deal of time, effort and resource to both learn the lessons needed, and to make our service even stronger and more robust moving forward."
• In February 2020, despite the reassurances given, the provider again found themselves in a position where they were unable to safely support their commissioned care packages. Systems for identifying and managing organisational risk were not effective.
• The provider's action plan implemented in autumn 2019 had not been sufficiently robust to protect the service from the same issues disrupting service delivery which indicated lessons had not been learned.
• The provider continued to lack the service oversight needed to assure themselves people received the care and support needed to promote their wellbeing and protect them from harm. Their quality assurance system failed to identify shortfalls within the service in January 2020 which led to further failures in service delivery and a significant increase in complaints about the service.
• Information to support performance monitoring was unreliable and local quality assurance systems within the service were not effective. For example, we looked at a selection of 'daily logs' where staff recorded the care they had delivered. These evidenced discrepancies in the length of calls, early or late calls, lack of information regarding the care provided and, in one log, staff had not recorded the time they left the call in 34 out of the 57 entries. All these logs had been audited and these issues had not been identified or explored.
• Other audits and checks were not effective because they had not identified the shortfalls we found. For example, inconsistent management of risks, the safe management and administration of medicines and ineffective management of complaints and safeguarding concerns. We also found the provider was not working in line with the requirements of the Mental Capacity Act (2005).
• Senior staff had been unable to effectively carry out their roles and responsibilities to manage service delivery because they had been required to complete care calls to ensure people's needs were met. One told us, "We were doing care calls all the time, we were just running. I feel there were errors happening and I wasn't able to jump on them at a moment's notice. Normally we would have been out there like a shot."

• The registered manager acknowledged our findings and told us one week they had 600 hours of unallocated care calls they had to cover. They felt this was due to retention challenges and difficulties in maintaining enough staff to meet the obligations of their contract with the local authority. They told us, "The company put in improvement plans but we plastered over rather than resolved problems." They told us they continued to raise their concerns in the early part of 2020 and added, "We needed more support and we needed something to change."
• The registered manager told us they had raised their concerns about contractual challenges with the local authority and described the actions the provider was taking to support the management team in addressing these. For example, reviewing staff remuneration packages, recruiting a new 'field care supervisor' to support the care staff and sub-contracting some care calls to another provider.
• However, 66 percent of the people and relatives we spoke with continued to give poor or mixed feedback about the quality of care they received from the service. They told us of missed calls, late calls, inconsistency in the staff who provided them with care, lack of knowledge and understanding of people's needs and poor communication. Comments included: "I feel so sad they are not very good. I'm so afraid to complain" and, "When I complained to the office (about missed calls), staff apologised but this is not the issue, they should get there and do the call. It's not acceptable this happens." This demonstrated a failure to make and sustain improvements to benefit people.
• Complaints were not always managed in accordance with the provider's complaints policy and lessons were not always learned. The complaints log contained three complaints dated 3, 20 and 26 June 2020 which did not have any actions or outcomes recorded. This indicated they had not been managed in line with the provider's policy timescales. One person told us, "I don't have much confidence in any complaint being resolved by the provider. I have to go to the social worker."
• The registered manager was due to leave four days after our inspection visit and we were not assured arrangements for the transition of the day to day management of the service were either robust or effective. During our conversations with the quality and compliance manager who had oversight of the service, we were consistently referred to the registered manager to answer our questions. A new manager was yet to be appointed.

Due to poor governance of the service people were placed at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider was in the process of implementing a more robust quality management schedule which demonstrated commitment to drive forward improvement. The schedule included increased frequencies for monitoring and meeting with staff and checking documents. However, the frequency of checks was not always clear.
• The quality and compliance manager and senior staff told us they wanted to provide high quality care and were confident actions now being taken would drive improvement. One senior staff member told us, "This year I have felt like we have been doing the basics. I would like to be where we were 18 months ago. I want to get back to quality and improving things." Another added, "I think we are getting there."

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
• Further improvement was required to demonstrate people's feedback was gathered and consistently used to drive forward improvement.
• Feedback from people was that not everyone had confidence in the complaints process because issues of concern continued despite complaints being raised.
• In the first six months of the year the service had received complaints about the quality and consistency of the care people received. In July and August 2020, the provider had carried out quality assurance calls to

people and their relatives and some people had continued to raise the same concerns. Comments included: "No consistency of carers", "Weekend carers show up at any time without notifying or do not come at all", "No communication from the office has left [Name] feeling vulnerable" and, "Office staff only helpful depending who you get through to."
• Some people were happy with the care provided and some people told us the care had improved recently. One relative told us, "They have listened over the past few weeks and things are finally getting a bit better. To give them their due I think this company is listening." Another relative said, "If I have any problems there is always someone at the end of the phone." A third told us, "Overall, over the last year I have not been greatly happy, but I recognise they are trying to do their best."
• Overall, staff felt supported. They told us the service had been through challenging times but felt confident improvements were being made. One staff member told us, "When I first started in June I was being rung quite often (every day) to see if I could take on more calls. Too many clients, not enough staff. This has settled down now and the last six weeks has been okay." Another said, "The managers are really good, if you have any problems you just get in touch with the office. They also get in touch with you regularly if they need anything, or anything changes. The communication is good."
• However, processes to support staff were not always effective. For example, one staff member had recently had an annual appraisal of their practice. The appraisal was incomplete and there were no comments on current performance or training and development objectives for the coming year.

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
• People did not always feel the service were open and honest when things went wrong.
One person told us, "One night they (care staff) did not come at all, it was about a month ago. I rang the office and they said they would see about it. I've heard no more. That's what you get, we'll see about it."
• The provider had sub-contracted some week-end hours to another care provider as they did not have enough staff to cover those calls. We received complaints about the other care provider and the standards of care. As the contractor for those services, the provider had failed to ensure standards were maintained and people received safe, effective care.

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 The provider did not adequately assess and protect people against risks by doing all that was practicable to identify and mitigate such risks.

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems and processes were not operated effectively to assess, monitor and improve the quality and safety of the service.

The enforcement action we took:

We issued a warning notice.