Total Care Norfolk Limited

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Inspection report

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Norfolk
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07 November 2019
13 November 2019

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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
Total Care Norfolk is a domiciliary care agency which provides care and support to people in their own homes in the Downham Market area.

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
The service was not well-led, and this had a negative impact on people's care and support. The nominated individual, who is legally responsible for the service, had not fully assessed and reduced risks to people's health and welfare. Systems designed to report significant information, such as accidents and incidents were not effective. The provider did not have oversight of the service and issues or poor care and neglectful practice had not been appropriately reported, investigated and addressed.

Recruitment procedures were not robust and did not fully protect people. Staff training was not delivered as soon as staff were first employed. This meant some staff did not have all the skills and knowledge they needed to carry out their roles safely. Staffing levels were not always well monitored and rotas did not easily enable staff to ensure all calls were timely.

Medicines were not always well managed. Records relating to medicines needed to be clearer to ensure staff had the guidance they needed.

Although some people who used the service were very happy with their care and we observed good care being provided, we are not confident in the provider. The provider failed to ensure all the people who used the service had safe care and treatment.

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

Rating at last inspection
The last rating for this service was good (report published 10 April 2018.)

Why we inspected
We received concerns in relation to untrained and unskilled staff, poor recruitment practices and poor management of falls. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led only.
We reviewed the information we held about the service. No areas of concern were identified in the other Key Questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection.

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

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

Since our inspection the provider has told us that they have taken action to implement new reporting systems. These have been designed to ensure key information about risks to people's health and welfare is monitored more effectively.

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

Enforcement
We have identified breaches in relation to the management of risk, management of medicines, leadership, staffing and recruitment at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan and 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 overall rating for this service is 'Inadequate' and the service is 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.

Total Care Norfolk

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 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.

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 would be in the office to support the inspection. Inspection activity started on 7 November 2019 and ended on 13 November 2019. We visited the office location on 7 November 2019.

What we did before the inspection
We reviewed the information we had received since the last inspection. We sought feedback from the local authority. 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 with four people who used the service and two relatives. We received a letter from a third relative. We also spoke with four care staff, the manager and the nominated individual, both of whom also carry out

regular care shifts. We observed staff carrying out some of their duties in people's homes.

We reviewed a range of records. These included six people's care plans, daily records in detail for two people and six people's medication records. We also viewed four staff recruitment folders and other documents relating to the quality and safety of the service.

After the inspection
We continued to seek clarification from the provider to validate the evidence we found. We requested to see additional recruitment records including disclosure and barring service checks, business insurance records for care staff, rotas and policies and procedures.

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 good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; using medicines safely

- People's risk of falls was not robustly assessed or well managed. We saw three entries in daily records for two people which documented falls. The falls were not reported to the provider and the manager and nominated individual told us they were unaware of them. There was no further action documented following the falls.
- These falls were especially concerning as one was described as 'backwards' and another was for a person on blood thinning medicines. There was no risk assessment relating to the person being on blood thinning medicines. A fall backwards or the presence of blood thinning medicines placed people at an increased risk of sustaining an injury which might not have been immediately clear to staff.
- Medicines were not always well managed. There were some missing signatures on the medication administration records (MAR). This meant it was not always clear that people had received their medicines as prescribed.
- Staff had signed one person's MAR chart even though they administered the medicines themselves. The procedure for self-administration was not clear and had not been properly risk assessed. The provider told us that they had discussed the matter with the person's relative and their GP but nothing was recorded. They told us, "It is in my head."
- Staff received online medicines training but their competence to administer medicines safely was not checked after they completed it. Staff new to care told us they lacked confidence in giving people their medicines.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- People who used the service told us that calls were mostly on time. However, we were alerted to one missed call during our inspection process. The provider told us their system had failed and they had not been alerted to the missed call as they should. The person concerned missed out on having their medicines and meal at the correct time.
- People who used the service and staff commented that staff don't have enough time between calls which can result in some calls being shorter than they should be. We reviewed rotas and noted that travel time between calls was minimal and sometimes there was no travel time. Some staff told us they ensured people got their full visit and made the time up elsewhere. Others said visits were sometimes significantly shorter than they should be.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

●Staff were not recruited safely. The provider did not ensure staff included a full employment history on their application forms. On one application references from a previous care job had not been taken up with no clear reason why. Three staff, who had been working for several weeks, had no references on file.
●When staff were recruited the provider carried out an initial check to ensure that they were not on a list barring them from working with vulnerable adults. They then applied for an enhanced check. This check makes sure staff did not have a criminal record which would make them unsuitable to work in this setting. The provider told us that staff were not allowed to work unsupervised until their enhanced check came through. However, rotas showed that staff were working unsupervised before this check was complete. This could have placed people at risk.
●Where staff had convictions or reprimands on their enhanced check, the provider had not risk assessed this to ensure people were not placed at any increased risk.

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

Systems and processes to safeguard people from the risk of abuse
●One potential safeguarding concern had not been appropriately referred and investigated. Records did not demonstrate that the provider took prompt action to ensure one person's alleged neglectful care was fully investigated.
●Staff received online safeguarding training during their first few weeks of employment at the service. Staff were sometimes working several weeks before they managed to complete this training. This meant that staff, especially those new to care, might not be clear about how to spot the signs and symptoms that a person was at risk of abuse. They might also not be sure about how to raise concerns.
●Experienced staff demonstrated that they had an understanding of how to keep people safe. However, we noted a longstanding maintenance issue where staff provided live-in care. The provider owned a bungalow and provided care to two people. The boiler had been out of action for several months and there had been limited access to hot water. This had impacted negatively on the health of the two people living there. Staff had not considered making a safeguarding referral for possible neglect.

Learning lessons when things go wrong
●The provider's reporting systems and lack of effective audits meant they were not always able to learn from incidents going wrong. For example, where people experienced falls, these were not correctly reported. This meant the provider had no opportunity to look at any patterns or trends to see if risks could be reduced.
●Where people who used the service, or their relatives, had raised issues relating to health and safety, the provider had not responded promptly and taken action to reduce the likelihood of a repeat incident.

Preventing and controlling infection
●Staff demonstrated a good understanding of infection control. They used appropriate equipment, designed to reduce the risk and spread of infection and had received training. However, this training was not always provided before they began to carry out personal care tasks.

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 requires improvement. At this inspection this key question has now 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider did not ensure some of CQC's regulatory requirements were met. There was no registered manager for this service. It is a requirement of the provider's registration to have a registered manager in place but there had not been one since 13 March 2019. The current manager had not applied to be registered at the time of our first inspection visit but did apply during the inspection process.
- The office location had moved from the provider's address to an alternative address. In this circumstance the provider is required to notify CQC. The provider had not notified CQC about this change despite being given clear advice about how to do this several months ago.
- The provider had not ensured that they had oversight of the service, even though both the nominated individual and manager both carried out some care shifts. They told us these visits constituted a spot check of staff practice but no records were kept of these. A lack of effective reporting systems and poor monitoring of accidents and incidents placed people at risk.
- The nominated individual and the manager did not work well in partnership with each other. The manager told us they had had no effective handover when they took up their post as the nominated individual was away for three weeks.
- We did not see evidence of robust action where issues were highlighted in records. For example, we saw that two staff had a disagreement about one person's care. Daily records were used for several days to trade allegations of neglectful care. The record stated that staff had reported the concerns to the manager. However, it was not clear that action had been taken promptly to ensure the person received the care they needed. No safeguarding referral had been made and records did not show that the matter was fully investigated.
- The provider told us that the electronic monitoring of care visits meant that any missed visits would be quickly identified. However, during the inspection process a call was missed and not noticed for several hours. This placed the person at potential risk of harm.
- Inadequate rota planning meant that staff did not have their travel time factored in which meant some calls were late or had to be cut short. This had the potential to impact negatively on the quality of people's care.
- Poor recruitment procedures did not protect people who used the service. The provider could not be assured as to the safety and suitability of staff carrying out unsupervised shifts. In addition, staff training was not delivered promptly to staff to ensure they had all the skills and knowledge they needed. This placed people at risk of avoidable harm and inadequate care.

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

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

●The provider was not always open and honest with us throughout the inspection process. Although they acknowledged that some standards of safety and quality were unacceptable, we also found that they were not transparent in all matters.

●Two relatives told us that they had not been kept informed of incidents or healthcare conditions affecting their family member.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● We received mixed feedback from people who used the service and staff about the culture of the organisation. The provider did not invite or respond to feedback. They had not carried out any recent surveys or questionnaires to find out what people thought of the care provided. One person had raised issues with the provider and told us they found the response from the provider was quite intimidating.

●Staff gave mixed feedback about the management of the service, Some told us they felt supported enough to raise issues while others stated they did not always feel their concerns were listened to.

●The manager and nominated individual carried out some care shifts. People who used the service told us they used these opportunities to discuss their care and make suggestions. One person told us they valued the opportunity to do this and had found the nominated individual very receptive and helpful. However, some people did not have regular care visits from the provider and so did not have the same opportunities.

Working in partnership with others

●The manager confirmed that staff routinely work in partnership with GPs and other healthcare professionals and records confirmed this. The service had worked alongside palliative care teams to support people's end of life care. However, this was not being provided to anyone at the time of the inspection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure that risks to people's health and safety were assessed and mitigated. They also failed to ensure medicines were managed safely. Regulation 12 (1) (2) (a) (b) and (g).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure they operated effective systems to assess, monitor and improve the quality and safety of the service and to assess, monitor and mitigate risks. Regulation 17 (1) (2) (a) and (b).

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to operate an effective recruitment procedure. Regulation 19 (1) (2) (a).

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure that there were sufficient numbers of suitably competent, skilled and experienced staff, who received appropriate training to carry out their role. Regulation 18 (1) (2) (a).