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

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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 24 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 were in place but were not effective. The provider's governance systems had failed to identify the concerns and shortfalls we found during our inspection. The concerns about ineffective systems, were repeated concerns over the three previous inspections.

Risks to people's safety had not been assessed accurately. Infection prevention and control (IPC) measures were not consistently followed. Medicines were not always managed safely, and recruitment procedures did not ensure staff were safe to work with people.

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.

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 15 March 2022) and there were breaches of the regulations. The provider completed an action plan and sent monthly reports to show what they would do and by when to improve.

At this inspection we found improvements had been made to meet the previous breach of regulation 13, safeguarding service users from improper treatment. However, enough improvement had not been made on the breach of safe care, employment of staff, and the governance of the service. The provider had failed to achieve a good rating over the last three inspections.

Why we inspected
We undertook this comprehensive inspection to check they had followed their action plan and to confirm they now met legal requirements.

We found evidence during this inspection that the provider needs to make improvements to ensure the risk of harm to people is identified, and action taken to reduce these risks. Please see the safe, effective, caring, responsive and well-led key questions of this full report.

The overall rating for the service remains as inadequate, based on the findings of this inspection.

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

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to; Regulation 12 – Safe care and treatment, Regulation 17 – Good governance, Regulation 19 – Fit and proper persons employed, at this inspection.

We issued a notice of proposal to cancel the providers registration.
Please see the action we have taken at the end of this 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 17 August 2022 and an assistant inspector who made telephone calls to people and relatives on 18 August 2022.

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 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 16 August 2022 and ended on 31 August 2022. We visited the office location on 17 August 2022.

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 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 12 people who used the service and five relatives. We also spoke with three care staff, the deputy manager 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 six 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 as 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. Some people who needed assistance to move, their risk assessment did not inform staff how to complete this task safely.
- 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. There were also occasions when only one staff member attended a two staff member call that required two staff members to ensure the person was supported to move safely. Some people who lived alone were not able to alert the registered manager, or anyone else, to the problems with their calls. This placed people at an increased risk of harm.
- Staff were not adhering to current guidance on the practise of lateral flow testing, (COVID-19 supplement to the infection prevention and control resource for Adult Social Care – published 31 March 2022).
- At the time of our inspection, the guidance was for staff to continue with twice weekly lateral flow device testing. The provider told us they had ceased weekly testing on 13 June 2022. This meant people and staff members had been placed at increased risk of infection.

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 as 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 relative had verbally informed the management team about the frequency of a prescribed medicine. This medicine was being administered every two days (48 hours), instead of the prescriber's instructions which should have been every three days (72 hours). The provider failed to have a safe system to check and verify the instruction from the family member.

● Where people received their medicines through a Percutaneous Endoscopic Gastrostomy (PEG), there were no protocols or guidance to say how this task had been delegated from the community nursing team. (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.
● Medicines for one person were given in close proximity to each other, due to the scheduling of the calls. For example, on six occasions in August 2022 two dosages were given within three hours of each other and on one of these occasions the administration of the medicines were less than 30 minutes apart. This is not in line with prescribing instructions for safe administration. The provider was unaware this was happening until we brought it to their attention, which meant the potential risk of harm to the person had not been explored.
● 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'. but there was no information about the prescription. 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.

We brought the concerns about medicine management to the providers attention so they could take the required steps to ensure people's safety.Following our inspection, the provider told us they have reviewed the timing of the care calls with the relatives to ensure there is adequate timing between medication administration.

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 fully implemented and the provider remained in breach of Regulation 19.

● Safe recruitment practices were not always followed. The provider failed to follow their own recruitment policy.
● A staff member was employed without any references. They commenced work in April 2022 and the reference on their file was dated July 2022.
● Another staff member declared on their application form they had not been employed before. However, their reference was from a health care setting and referred to them working in a care setting. The provider had failed to identify and check the validity of the refence prior to the staff's members employment.

Recruitment procedures were not operated effectively. This was a breach of Regulation 19 (Fit and proper person employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
At the last inspection we found a breach of regulation 13. Staff had not received safeguarding training and safeguarding concerns had not been reported in line with safeguarding procedures. At this inspection this breach had been met although further improvements were still required.

● The provider told us they had completed their investigation into recent safeguarding concerns raised by a family member about their relative's care. The safeguarding concerns remained open whilst the local authority completed their part of the investigation.
● The provider's systems to recognise and take action, on poor practice were not always effective. For example; where calls were late, missed or one staff member was in attendance instead of two, 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.
● Staff had received safeguarding training. Staff told us if they saw poor practice they would report it to the deputy manager or registered manager. A staff member told us, "I would tell the management if there were concerns and if I needed to I would go to CQC."

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 always 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. Also, when peoples' needs or choices changed, this was not always accurately reflected in people's care plans.
- One person was unable to communicate verbally or move to indicate their needs, wishes and feelings. We found they did not have a care plan to guide staff on what they should look for to identify if the person was happy, sad or in pain. 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 previous inspection we found staff did not have the relevant training to carry out specific care tasks. At this inspection we found staff were supporting a person with a PEG feed and medication, and the required training and competency assessments had not been completed. This placed the person at an increased risk of harm.The provider told us following our inspection they provided the staff with the required Peg training.
- Staff confirmed spot checks of their practice were carried out. Staff told us the checks included ensuring they were wearing the correct PPE and uniform and that the care call was being completed as required. The spot checks had however, 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.
- Staff told us when they first started working at the service, they received an induction. This included shadowing other staff members, on-line training and face to face training in the office.

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. However, more detailed information was needed where a person's capacity may vary and posed a potential risk to themselves or others.

● 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

● A person's care plan said they were receiving support from the district nurse service. When we asked for information about this, the provider was unable to tell us. 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. For example, a staff member was able to tell us the actions they took to support a person who had a fall when they arrived at their home.

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. One person had a change in how their food should be prepared and there was inconsistent recording about this in their care plan.

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 comprehensive 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. Five of the 17 people/relatives we spoke with had experienced a missed or late call.
- One person told us, "Last week they did the morning call but didn't do the evening call." A few people told us they had experienced missed calls at the weekend. One person told us, "Occasionally the staff do not turn up, this is mainly at the weekend and I have to ring Tabitha to say that the carer has not arrived. They will find out where the carer is and will ring me back." Another relative told us, "They [staff] missed a few calls. It happened mainly at the tea and night-time call."
- Many people were very happy with their care. One person told us, "I am very pleased with everything so far." Another person told us, "If there is any reason why the carer is going to be late, they will always inform me in advance, so that I can make arrangements. If we ask them to adjust the time for us, for example, to attend a hospital appointment they are very accommodating."
- People's care plans included some information about their preferences and personal histories.
- Staff we spoke with understood peoples' support needs. A staff member told us, " Our job is hard, risky and rewarding, we do our best. I feel I go over and above to help the people we support."

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

- Most people told us staff would ask them about their care and how they wanted to be cared for.
- 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 those people in decisions about their care.

Respecting and promoting people's privacy, dignity and independence

- Some people raised some concerns about their care. One person told us, "[Staff member's name] was always on their headphones. Sometimes they would not hear what you were saying as they were too busy listening to music with the earplugs in their ears."
- The majority of the people we spoke with were satisfied with their care. A relative told us, "The lady who came today was the regular one and she gives [person's name] a laugh because she comes in singing and dancing and that makes her happy. It is more personal rather than somebody just turning up to do the job." Another person told us, "I am quite happy as I don't need that much care. I can assure you that if I wasn't getting the care I paid for, we would be straight on it."
- Staff told us they supported people to maintain their independence by encouraging them to do as much as they were able to do for themselves.

● Staff spoke about people respectfully and shared examples of how they had got to know people and their individual preferences.

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 a number of recent care calls and identified multiple problems. For example, shortened calls and calls considerably earlier or later than planned. A person told us, "The main concern is staff putting me to bed too early. It is a long time to be in that position, it doesn't do my body any good. I am not tired at 8.30pm." Another person told us, "The staff are not carers they are grafters, running from one call to the next to earn a living."
- Care plans contained personalised information about people's likes and history. However, some care plans lacked information about specific health and care needs. For example, there was no care plan in place for people who had epilepsy which can cause seizures or unusual sensation and behaviour. There was no care plan in place for Alzheimer's which is a physical disease that affects the brain, that can causes problems with memory, thinking and behaviour, and is a progressive condition. Care plans would guide and inform staff about how to support a person's communication, confusion and disorientation when they had a diagnosis of Alzheimer's disease.
- 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. They told us they had received no recent complaints.
- Most people and relatives we spoke with told us if they had any problems or needed to change a call or need to ask about a staff member who hadn't arrived, they could contact the office and staff were helpful.

However, some people lived alone and were not able to raise concerns about the quality of their care call

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 is the fourth consecutive inspection where the provider has failed to meet the regulations. There have been repeated breaches in relation to safe care and treatment, good governance and fit and proper persons across all four inspections.
● The provider had systems in place to assess, monitor and improve the service. We found these systems had not been effectively used and had not identified concerns found during this inspection.
● There were ineffective systems to ensure medicines were always managed safely. The provider's oversight of medicines had not identified they were not always given as directed by the prescriber and dosages of some medicines were given too closely together which placed people at risk.
● The provider's oversight had failed to identify that clear instructions, protocols, staff training and written local agreements were not in place for tasks delegated to care staff. For example, medicines administered via a Percutaneous Endoscopic Gastrostomy (PEG).
● The provider's systems to monitor the quality of risk assessments and care plans had not been effective in identifying that care plans lacked detail about specific care needs and were not in place for some health conditions. For example, epilepsy and Alzheimers disease.
● The provider's systems to monitor recruitment processes had failed to identify they were not following their own procedures, which placed people at risk of harm, of being supported by staff who were not suitable.
● 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 not kept up to date with current government guidance in place at the time of our inspection on COVID-19. Staff were not completing twice weekly lateral flow device testing. This meant people and staff members had been placed at an increased risk of infection.
● The provider had implemented a risk log to capture areas of improvement they were working on. For example, following a recent quality inspection by the local authority, shortfalls in recruitment were

identified. Recruitment processes was added to the risk log and actioned as completed. However, their own checking processes were ineffective because we identified additional recruitment shortfalls at this inspection.
● The provider had completed an action plan following our last inspection and provided monthly updates to CQC. This had not been effective to make and sustain the necessary improvements to ensure people received good quality care.

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 through COVID-19. They told us they felt they were making steady progress and felt things were moving in the right direction.
● The provider cooperated fully with the inspection and provided the information we requested. When we identified an issue, they took some action to address the concerns. However, this showed they were a reactive and not a proactive service. 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 very happy with the care provided. One person told us, "It was good as first but now it is dropping off. Sometimes they[staff] just sit there and talk on the phone to their relations." Another person told us, "At the moment things are okay. If there was something wrong, I would say something."
● 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, there was no audit trail to show the action taken by the provider. For example, one person raised they wanted the time of the morning call changed, and another person reported missed calls at weekends. There were no follow up actions to show this feedback had been addressed.
● Staff were positive about the support they received to carry out their role. They told us the registered manager and deputy were very approachable.

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 Systems in place did not ensure people received safe and care treatment

The enforcement action we took:

NOP to cancel registration

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place for oversight of the service were ineffective

The enforcement action we took:

NOP to cancel

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Systems in place for safe recruitment were not effective

The enforcement action we took:

NOP to cancel registration