Teonfa Limited

Teonfa Ltd

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?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Teonfa is a domiciliary care agency providing personal care to people in their own homes. 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. At the time of the inspection, the service was supporting 42 people, all of whom were receiving personal care.

People's experience of using this service and what we found
People did not receive reliable and consistent care. Care visit times were late and this meant some people did not always feel safe due to feeling that staff rushed their care and did not listen to them.

Audits failed to identify concerns about the inconsistent care visit times and missed medicines, which were not managed safely.

Risks were identified but measures to manage the risks were not clear and there was a lack of guidance for staff to follow. Staff did not understand how to keep people safe or how people's various health conditions impacted them.

People were somewhat protected from the risks of the COVID-19 pandemic but people told us not all staff always wore their masks correctly or washed their hands.

People's complaints were not always resolved and lessons learnt from concerns did not always result in a practical change or an improved experience of care. People felt communication from office staff could be better.

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 (published 5 February 2019).

Why we inspected
We received concerns in relation to the management of care visit times, medicines, response to complaints and people's care needs not being met. 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 requires improvement. 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.

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 inconsistency of care visit times, clear communication and reporting. We have also found concerns about how staff were guided to keep people safe and staff understanding of their roles. We found there was a failure to effectively monitor and improve the quality of care 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 from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Teonfa 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
This inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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
We gave the service 24 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority, Healthwatch England and professionals who work with the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used the information the provider sent us in the provider information return. 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. We used all of this

information to plan our inspection.

During the inspection
We spoke with 11 people who used the service and nine relatives about their experience of the care provided. We spoke with fifteen members of staff including the nominated individual, registered manager, office staff and care workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included eight people's care records and medication records. We looked at two 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 training data and quality assurance records. We spoke with three professionals who regularly worked with the service.

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 this key question has now 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.

Staffing and recruitment; Assessing risk, safety monitoring and management; Using medicines safely

- Care visit times were inconsistent, often late by two hours or more and staff did not stay for the full length of the agreed time. This led to some people not receiving their care in a timely manner and people told us it caused them distress not knowing if or when staff would come to support them.
- Despite measures put in place by the registered manager, this has continued to be a concern for people over the last five inspections by the CQC. One person told us, "[Staff] are really kind, but extremely unreliable. I have four visits a day. Sometimes I only get three visits. I never know when they will arrive. I can never plan anything." Another person said, "I am not happy with the service. The night-time visit should be 9.00pm and sometimes it can be 11.30pm. They don't stay very long. Occasionally there is no call at all. I find it all very distressing. Some visits are very rushed."
- Following the inspection we received further concerns shared by external professionals about late care visit times and staff entering people's homes outside of agreed hours. It was alleged a missed care visit had resulted in one person not receiving food, drink or personal care for 16 hours. An enquiry had begun by the safeguarding team to review these concerns. A relative said, "[Staff] are not on time. Every day they are late, sometimes two hours late. This upsets routine, food and medication times. The agency will ring to say they are running late and tell me a time they will be arriving, but you can't rely on it." Where people were at risk of harm, we have made referrals to the adult protection team at the local council.
- The registered manager had identified risks to people in relation to moving and handling and mental and physical health needs. For example, falls risks and diabetes. However, there was no clear guidance for staff to follow to understand what to do to reduce those risks and ensure safe care was being delivered.
- Staff were not aware of what the medicines were that they were administering and whether or not any of these had special instructions. Staff were also unaware if any medicines must be administered at specific times in order to work effectively.
- One person's medicine administration chart stated they had medicine for epilepsy and seizures, but their care plan did not mention anything about this. This risk had not been assessed or recorded. People told us of other concerns. One person said, "There are no set time for visits, so my medication is not taken at the right time." A relative said, "Medication should be given three times a day. One of the staff found two tablets in [my family member's] bed so they had obviously not had them. They are found all over the place on the floor."
- There was not always guidance in place for staff to know when, how and why to administer medicines that were prescribed to be taken 'as required'. Staff did not always complete the medicine administration records. There was no clear evidence that this had been investigated to determine if medicine had been missed.

We found some evidence that some people had been harmed. Risks to people were not safely managed. Systems to keep people safe such as staff guidance, care visit schedules and medicines were not robust enough. This placed people at risk of further harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during the inspection and told us about new staff teams they had put in place to cover care visits when staff were late. They had also introduced new auditing systems using a newly implemented electronic care planning system. This enabled them to monitor care delivery live. However, these were not yet used effectively and had not yet had a positive impact on the care people experienced.

● While there were concerns about staff deployment, there were enough staff on duty to meet people's needs. Staff told us they were also given enough time to travel between care visits and to carry out the tasks required but that there were problems with drivers arriving late or other staff not being ready when the drivers came to collect them. This had a domino effect for all care visit timings for all staff involved.
● The registered manager completed checks on new staff to ensure they were suitable for the role. The staff were able to show us plans for a new procedure for recording future recruitment.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Some people said they felt safe as the staff were friendly. Other people told us they did not always feel safe due to never knowing who will be coming into the home and not always feeling listened to.
● The provider had systems in place to identify and monitor incidents and concerns. However, they did not always report these to the CQC. Staff did not have a good understanding of how to keep people safe or how to identify and report various forms of abuse.
● The registered manager had records that showed incidents had been reflected on and lessons learnt identified. These had been shared amongst the staff team and with people, their relatives and health and social care professionals involved. However, these did not always translate to the care experience and people told us they had not seen improvements.

Preventing and controlling infection
● We were assured that the provider was meeting shielding and social distancing rules.
● We were somewhat assured that the provider was using PPE effectively and safely. We observed office staff following the correct procedures. Staff understood how to use PPE safely. However, people told us staff did not always wear PPE correctly in practice.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

Requires Improvement

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 remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred 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

- Quality monitoring was not effective. Audits showed staff had not always identified the concerns in relation to late care visit times and the length of time staff stayed. One audit for a two-week period showed for one person that all visits had been met. However, daily diary records for the same period showed there were 44 late care visits and six missed ones. This had not been identified by the audit and there was no plan of action of how this would be addressed.
- Another person's care records showed care visit times were late by more than 30 minutes, for 127 care visits out of a total of 320. There was no evidence of whether the registered manager had analysed incidents to identify trends and take appropriate action.
- CQC notifications had not always been submitted for notifiable events. The provider agreed to ensure this happened, but we have had to ask for these to be submitted on two occasions following the inspection. This showed the provider was not always open when something went wrong.
- Staff did not understand the various conditions that people they supported had or how this impacted them. For example, diabetes and dementia. They also struggled to understand safeguarding or the principles of the Mental Capacity Act and how to ensure consent was sought.
- Staff's lack of skills and knowledge meant people were not always safe and in control of their care. People and relatives told us how concerned they were about staff who did not seem well trained. One person told us, "I feel nervous when [staff] use the hoist. Some [staff] are trained, some not and I feel very rushed. Sometimes the sling is not put on correctly [on my hoist], depends who is using it. They don't take enough time with it." A relative told us, "The bottom line is the [staff] themselves. A lot are not trained. Some don't know what to do before they get here."
- The registered manager did assess staff competency and knowledge. However, this was ineffective as it did not pick up concerns found at this inspection, about staff understanding of their role or how well they applied this to their care practice.

We found some evidence that some people had been harmed. Systems were either not in place or robust enough to demonstrate quality and staff competence was effectively monitored and managed. This placed people 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 responded during the inspection and told us about plans they had to develop staff knowledge and practice. They had also employed staff in new roles to better monitor quality. These were yet to show improvements in people's care experience or be fully embedded.

● The provider displayed their CQC rating in the office for everyone to be aware of.
● The registered manager and senior management team did understand the requirements of their roles and had good ideas for developing and improving the service. These included local networking meeting with a selection of health and social care professionals to identify trends in the area and look at how to address them in a coordinated way.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The care planning system did support identifying personalised care such as including information about people's life history and likes and dislikes. However, this needed to be further developed and guidance for staff about meeting people's needs in a personalised way was missing.
● People's care could not be person centred in practice due to the inconsistency in care visit times. A relative said, "The [staff] can rush [my family member] and they hurry away early telling us they have lots of other people to see."
● People also told us there were language barriers with staff who they felt did not understand what they told them they wanted or needed. One person told us, "Depends on who comes. Some [staff] don't speak English. Some don't speak at all. It can be hard to explain to them what needs to be done. A high turnover of staff and no introductions."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People's feedback about engagement was mixed. Some people told us that their views were sought, and problems quickly resolved. Other people told us they did not feel they were listened to and no action was taken to resolve their complaints. People told us they felt the registered manager was approachable but other senior members of the management team could be very defensive when they raised a concern.
● The registered manager had employed a psychologist to work with staff on their well-being and offer additional support due to the anxiety caused by the COVID-19 pandemic.
● Most staff told us they felt supported by the management team. Other staff felt they were not supported and had concerns about their pay and how this was calculated.

Continuous learning and improving care
● The registered manager had a lot of evidence of identifying lessons learnt and encouraging development of the staff team. However, there was a disconnect between what was in place and the care delivered. We discussed how the provider will need to identify different approaches to identifying why some concerns continue and how they can make a difference in practice.

Working in partnership with others
● Feedback from professional was also mixed. One professional told us how they felt the registered manager had gone above and beyond to ensure one person's needs could be met. Another professional told us about how they had struggled to ensure staff followed instructions left about how to support people, which had impacted on the person's mobility. However, they later confirmed this had improved recently.
● Another professional who works closely with the service told us how they have found it difficult to engage with the registered manager and senior management team to work on improvements. They said this was due to the management team not accepting feedback constructively. They also felt the provider lacked

transparency and a focus on care delivery.

We could not improve the rating for well-led from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive 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 Risks to people were not safely managed. Systems to keep people safe such as staff guidance, care visit schedules and medicines were not robust enough.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were either not in place or robust enough to demonstrate quality and staff competence was effectively monitored and managed. This placed people at risk of harm.