Tipton Home Care Limited

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Inspection report

5 Venture Business Park
Bloomfield Road
Tipton
West Midlands
DY4 9ET

Tel: 01215573649
Website: www.tiptonhomecare.co.uk

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Ratings

Overall rating for this service	Requires Improvement
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an announced comprehensive inspection at this service on 29 and 30 September 2016. We found the service was in breach of one regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. This related to there being ineffective quality monitoring systems in place to monitor the quality of the service provided to people. This meant the service was not well led because people did not receive care or support at the times they had needed it. At times care staff did not arrive at all and people did not receive any care. The provider had no effective system in place to show how they monitored and improved this aspect of the service. People could not consistently access the service by telephone because there were lengthy delays in answering their calls. People's care had not been reviewed with them and when they had shared their views about the quality of the service the provider had no system in place to share the outcome or any proposed action to make improvements.

After the inspection, the provider wrote to us telling us what action they would take to meet the legal requirements in relation to the breach.

We undertook an announced focused follow up inspection on 30 March 2017. This focused inspection was to check that they had followed their action plan and check that they were meeting the legal requirements. Whilst we found that some improvements had been made in some areas, systems in place to monitor and improve the service were not being used consistently. This report only covers our findings in relation to those requirements.

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

Tipton Home Care Limited is registered to provide personal care services to people who live in their own homes. People who used the service had a range of support needs related to age, dementia, learning disabilities, mental health, physical disabilities or sensory impairment. At the time of our inspection 360 people were receiving support.

There was no registered manager in post. The recently appointed manager was applying to be the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act (2008) and associated Regulations about how the service is run.

Some improvements had been made to ensure that people received the support they needed at the times that they needed it. The provider had introduced a new electronic call system to assist them in planning and scheduling people's call times. However some people had continued to experience missed or late calls and the impacts of this had meant their care needs were not met consistently.

Additional call handlers had been employed and people reported they could contact the office more easily and without long delays before someone would get back to them.

The systems in place to monitor the quality of the service were not fully effective across all aspects of the service because audits were not been undertaken consistently.

Whilst we heard from people that they were contacted about their views the provider's system to analyse people views and drive improvements was limited. The provider had begun to consult people about their care but the review process had not ensured people's views were captured or their care plans updated with essential information.

The recording of complaints had improved but not all complaints were captured or acted upon.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Some people and their relatives told us the service was not always managed in a way that ensured their needs were met. People identified some improvements such as being able to contact the service more easily.

The provider had made some improvement to the way they managed people's call times. However quality assurance systems and governance arrangements were not fully established to ensure the safe and effective running of the service.

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.

Tipton Home Care Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an announced focused inspection of Tipton Home Care Limited on 30 March 2017. We gave the service 48 hours' notice of the inspection because the location provides a domiciliary care service to people in their own homes and we needed to be sure that the provider or manager would be in.

This inspection was done to check that improvements had been made to meet legal requirements planned by the provider after our comprehensive inspection on 29 and 30 September 2016. We inspected the service against one of the five questions we ask about services: Is the service well-led? This is because the service was not meeting some legal requirements in this area.

The inspection was carried out by one inspector 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.

We checked the information we held about the service and the provider. This included the provider's action plan, which set out the action they would take to meet legal requirements. We also reviewed complaints shared with us by people who used the service. We received information about the service from Sandwell Local Authority. They have responsibility for funding and monitoring the quality of the service they commission on behalf of people who use the service.

We visited the provider's main office location. We spoke with 18 people who used the service, five relatives, five members of staff, the human resources manager, the manager and the provider. We looked at eight care plans for people that used the service, eight review records related to people's care packages, the complaints records, the electronic call system and records related to the management and quality of the service including audits on staff competencies and the call logging system.

Requires Improvement

Is the service well-led?

Our findings

We last inspected this service on 29 and 30 September 2016. During that inspection we found that the systems to monitor the quality and safety of the service [Governance] had not been effective. The impact of this on some people was significant as they had experienced missed or late calls on a number of occasions which left them without the support they needed. People had not had communication from the provider to alert them to late calls and they had difficulty trying to contact someone at the office for help. There was a lack of audits and checks within the service to ensure it was operating safely and offering people a good quality service. Audits were not in place to monitor the quality of care people received, call times, medication records or complaints made about the service in order for shortfalls to be identified and improvements to be made. This was a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014.

The registered provider was required to take action to improve the leadership and governance of the service. They sent us an action plan to show us how they intended to make improvements. During this inspection we looked at the improvements the registered provider had made.

We found that the provider had taken some action and made the required improvements to ensure they were meeting Regulation 17. Whilst the impact of late or missed calls on some people had reduced from what we found at our previous inspection, this most recent inspection identified that further improvements were still needed. This was because the size of the service meant the provider needed more time to establish such systems and to be able to sustain the changes and improvements across the service to ensure all people had their calls on time.

The provider had introduced an electronic call system and organised carers into geographic areas so that the same 'team' of carers covered a specific area. Care staff we spoke with told us they texted into the system to show they had attended the call. An alarm was activated if care staff did not text into the system and another care staff member from that team would be directed to a person's home. This had reduced the number of missed calls and the lateness of calls. Care staff told us it was 'less chaotic', 'more organised' and one care staff member said, "Less occasions now when we are sent all over the place at short notice to cover calls, that was the main problem". Care staff told us that their travel time had reduced due to working in 'teams' in areas.

We spoke with people to ask for their views of the service in relation to the missed calls. Most people described that this had improved. Their comments included; "There had been missed calls but a while back now, there haven't been any recent ones", "The one (care staff) I've got now does (arrive on time) but in the beginning they didn't ... they sent anyone", "I'm starting to get regular ones (care staff) now. It's picking up", "It's not too bad; they're mostly the same ones (care staff) now, but it's better than it was". Asked if they had regular care staff a person told us, "Only in the last few weeks, before I saw 10 to 15 different carers". And another person stated, "I do now, yes, over the last few weeks I have the same two carers". Relatives told us, "There does seem to be a main few (care staff) who come the most now". And, "It's improved; (name) has mostly regular ones (care staff) now". Whilst we heard from some people that they were happy with the

improvements made some people told us they continued to experience late or missed calls. One person said, "They came knocking on our door at 11:15pm ... they were meant to arrive between 8 and 9pm, I can't get up to sort it". People described the impact of care staff arriving late or missing their call. One person told us, "It's massive, I need help getting breakfast or I go without, I'm not able to apply the gel to my legs it's for the pain; if they don't turn up I'm in pain". Another person said, "I can't do things myself, if I'm left I can't dress or change my pad". A relative described the impact on their family member when the evening call was late followed by a late morning call; "If they don't come on time there's a big gap for (Name), in bed 15 to 16 hours; wet, unhappy and uncomfortable". People told us that they had complained to the provider and for short periods it had improved but they were not sure if this could be sustained.

The provider told us that recent issues with late/missed calls were in part due to sickness and vacancies and that they envisaged this improving with their recruitment drive and review system. A newly recruited Quality Control Officer (QCO) had been appointed in order to improve their quality monitoring via consulting with people who used the service. Some people told us they had been consulted about their care whilst others had not. Comments included; "Two came out they asked us if everything was alright ... if we're happy with it". Another person said, "No, I don't think anyone has been". We looked at the most recent reviews undertaken by the QCO as well as the provider and manager who had also undertaken some visits to consult with people. However the quality of these reviews varied considerably. In three cases the review form was blank and in five there was limited information. The provider acknowledged that the quality of the reviews was variable. He advised that quality monitoring of the review process was not yet established but would be addressed with the manager and the QCO so that the standard of written reviews improved.

Since our last inspection the provider had improved their records of complaints by ensuring there were sufficient written details as to the investigation and outcome. We saw this included feedback to the complainant. For some people there had been a positive impact as for example their call times had been altered. However we found that there were still some gaps in how complaints were picked up and managed. We saw for example that reviews of care undertaken by the provider identified three complaints about late/missed calls but there was no information to show these had been investigated as a complaint and therefore there was no record of action taken to rectify these concerns. Prior to our inspection we had received complaints from people about late and missed calls. These had been shared with the provider who had taken action to improve people's experiences. We found that whilst some improvement had been made the systems in place were not sufficiently established to ensure the provider could identify and act on all complaints. The monitoring of this area was not effective. The provider told us they would look at their processes to ensure any concerns raised during reviews were addressed under the complaints process.

People told us there had been improvements in being able to contact the office if the care staff was late or did not turn up. One person said, "They're not often late….they rang at 7:30am to say it would be 9am today. We are impressed with that ... as long as we know, it's okay". Another person stated, "Yes I can get through on the phone now and they try to be helpful ... they try to send another staff as soon as they can". We saw that the provider had employed additional staff as 'call handlers'. During our inspection we observed that although the phone lines were busy they were answered within a reasonable time. The provider showed us how they handled and recorded contacts related to missed or late calls these were entered in the electronic system or the communication book so that the provider could check a care staff member had been sent to the person. The provider had also purchased other equipment to place in people's homes where there was no phone line. This would enable care staff to text in on arrival at the person's home and therefore it was anticipated that the occurrence of missed or late calls could be monitored more effectively alerting the provider to provide an alternative care staff member quickly. However this system had only been in place for a short while and therefore the improvements could not be fully measured at this time.

Whilst the provider had begun to review people's care and update their care plans we saw that some essential information was missing from some care plans. For example a person's care plan had not been updated to show what action the provider had taken to ensure care staff understood how to manage a person's oxygen. Another person sustained a skin tear whilst being supported by care staff. This incident had been reviewed but the person's care plan had not been updated to show they had fragile skin or to guide care staff. The manager told us these care plans would be updated to reflect people's care needs. We will monitor the progress in this area on our next visit to the service.

Although quality audits were in place these had not been undertaken consistently and as such had not been fully effective in addressing outstanding issues. Whilst we heard from people that they were contacted about their views the provider's system to analyse people's views and drive improvements was limited. The complaints system had not been reviewed to test its effectiveness. The new review process had not ensured people's views were captured or their care plans updated with essential information. The provider told us that they recognised the need to establish a more robust quality assurance system. They had introduced additional call handlers and a new electronic call system to address the shortfalls from our last inspection. However the systems in place to monitor the quality of the service were not fully effective across all aspects of the service.

The manager was in the process of registering with CQC to become the registered manager. They were aware of their legal obligations to keep us notified of accidents and incidents that occurred in the service. They were working to the provider's action plan so that the shortfalls identified at our last inspection could be rectified. The leadership structure was not fully developed because the improvements which were required had not been clearly delegated and there was a lack of management oversight as to who was taking responsibility.

Providers are required to display their CQC ratings. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. During our inspection the ratings were not displayed in a conspicuous place or using a suitable format such as the ratings poster. The provider rectified this the following day and sent us evidence that their ratings poster was displayed within the service.