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

Date of inspection visit:
02 December 2021
17 December 2021

Date of publication:
15 March 2022

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Tabitha Homecare Ltd is a home care agency providing personal care to 42 people at the time of the inspection. 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 provider did not always identify safeguarding concerns or share safeguarding information with external agencies. Risks to people's safety had not been assessed accurately. Infection prevention and control (IPC) measures were not effectively managed. Medicine records showed medicines were not always given as prescribed. Recruitment procedures did not consistently ensure staff were safe to work.

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 02 June 2021) and there were multiple breaches of regulation. After the last inspection, we varied the conditions of the providers registration, requiring the provider to send a monthly report to the CQC setting out the results of their quality assurance activities and any actions taken to improve the service. At this inspection enough improvement had not been made/sustained and the provider was still in breach of regulations.

Why we inspected
This was an 'inspection using remote technology'. This means we did not visit the office location and instead used technology such as electronic file sharing to gather information, and video and phone calls to engage with people using the service as part of this performance review and assessment.

We carried out an announced focused inspection of this service on 20 April 2021. Breaches of legal requirements were found. Following that inspection, we received concerns in relation to infection prevention and control (IPC) and staff recruitment processes and practices.

We undertook this focused inspection to look at the concerns raised and to check the provider now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements. The ratings from the previous comprehensive inspection, for those key questions not looked at on this occasion, were used to calculate the overall rating on this inspection. The overall rating for the service has remained Inadequate. This is based on the findings at this inspection.

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

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 risk assessments, IPC, recruitment, medicines, oversight of the service and acting on safeguarding concerns.

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

Follow up
We will continue to monitor information we receive about the service until we 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 remains 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 of 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Tabitha Homecare Ltd

Detailed findings

Background to this inspection

The inspection
We carried out this performance review and assessment under Section 46 of the Health and Social Care Act 2008 (the Act). We checked whether the provider was meeting the legal requirements of the regulations associated with the Act and looked at the quality of the service to provide a rating.

Unlike our standard approach to assessing performance, we did not physically visit the office of the location. This is a new approach we have introduced to reviewing and assessing performance of some care at home providers. Instead of visiting the office location we use technology such as video or phone calls to engage with people using the service and staff and electronic file sharing to enable us to review documentation.

Inspection team
The inspection was completed 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.

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. At this service the registered manager was also the providers nominated individual (NI). The NI is responsible for supervising the management of the service on behalf of the provider.

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

Inspection activity started on 02 December 2021 and ended on 17 December 2021.

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. This information helps to support our inspections. We used all of this information to plan our inspection.

During the inspection-
We spoke on the telephone to nine people using the service and three relatives, about their experience of the care provided. We spoke on the telephone with eight members of staff including the deputy manager and seven care workers. We spoke to the registered manager using video call facilities and by telephone.

We reviewed a range of records. This included 10 people's care records and multiple medication records. We looked at four staff files in relation to recruitment records. A variety of records relating to the management of the service, including 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 the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse
At the last inspection, the provider was found to be in breach of Regulation 13. At this inspection we found the required improvements had not been made and the provider remained in breach of regulation.

● The registered manager did not always act on staff concerns for people's safety. At this inspection we identified six concerns relating to people's safety, that the provider had not considered as safety concerns. This information has been shared with the relevant external agencies so these concerns could be investigated, and action taken to ensure people's safety. One staff member spoke of a concern they had raised stating, "I reported this two months ago and nothing has happened."
● The provider did not support staff to report concerns or protect their confidentiality. One staff member said, "After I reported the concern, the care worker told me they didn't want to work with me, because I had reported this, and they didn't want anything reported." We brought this to the provider's attention who said, "I am aware of this," but had not taken any action to address staff behaviours that undermined the safeguarding processes or taken steps to address the issues relating to confidentiality.
● Not all staff received safeguarding training. One staff member said, "No I haven't had any safeguarding training", the provider records confirmed this.

This is a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they understood their responsibilities to report concerns affecting people's safety. Staff were able to give examples of reports they had made to the provider.

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 made and the provider remained in breach of Regulation 12.

● Where risk's to people's safety had been identified, action had not always been taken to keep people safe. For example, one person, with a memory impairment, walked using a walking stick and frame. The care plan set out staff should carefully monitor mobility transfers from a standing to a seated position. At a service review the deputy manager had identified the person was experiencing falls but had not assessed the risk or provided information for staff on how to support the persons mobility safely.
● The deputy manager identified that people experienced behaviours that caused them distress, this was not always understood and information about how to keep them safe was not always available. For example, one person's care plan stated, "It presents itself more as stubbornness and less as acting out." The

deputy manager did not assess this risk or provide staff with information about triggers and methods of de-escalation, to keep the person safe.

Using medicines safely; Preventing and controlling infection

● Staff did not have accurate information to enable safe administration of medication. Information in care plans was not always the same as that on Medication Administration Records (MAR) and not all medicines administered or prompted by staff were listed on MAR charts. For example, one person's relative informed staff directly, which medications were to administer and when. Another relative had given written information of medication changes to the service, these were acknowledged, however the deputy manager did not accurately update the care plan and MAR chart. We took immediate action to safeguard this person to ensure their medication needs were met safely.

● People and their relatives told us that staff do not always wear PPE. One person stated, "No PPE not even when using the commode." A relative stated, "[Name of person] doesn't feel safe as staff on the morning and lunch call do not wear masks or aprons, we have challenged this and staff said they we're double vaccinated and don't need to wear one, the tea time carers were found in the house with no uniform or PPE and the deputy manager was also seen in the house without a mask. I speak to [Name of provider] about the Masks, but nothing changes." Other relatives told us how staff previously wore PPE but had now stopped, one relative stated, "When Covid first started they wore the full gear, now sometimes they wear masks but not always, they haven't always got them with them." Another relative stated, "I don't think I've seen people with PPE for months they used to wear gloves but not aprons."

This is a breach of regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 required improvements had not been made and the provider remained in breach of Regulation 19.

● We found one staff member had been working in people's homes without a valid Disclosure and Barring Service (DBS) check. A DBS check would inform the provider if a staff member had criminal convictions or had been barred from working with vulnerable adults. The provider had not assessed the risk of this staff member working without the relevant checks being completed. This was brought to the attention of the provider who then completed a risk assessment. The risk assessment was ineffective as it did not set out the risks posed to people using the service, how the risks would be mitigated or how the provider would maintain oversight and management of the risk posed.

● Another staff member, who had since left the service, had been working in people's homes without a valid DBS check. The recruitment file also contained information of concern, that had not been risk assessed by the provider.

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

● People using the service, their relatives and staff gave mixed views on staffing levels. One relative told us, "They try hard to do as much as they can, [name of person] is safe with the carers but they don't have enough time. I get the feeling talking to [name of person] and the carers there are too many calls for them to fit in. There's no consistency with timings and it affects the medication." One person told us, "[Staff member] is fabulous, arrives on time, a cheerful ray of sunshine." A staff member told us about the difficulties getting to calls on time stating, "There is no travel time."

Learning lessons when things go wrong

- Lessons from the previous inspection had not led to sufficient improvements to meet regulated activities.

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. 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. These assessments identified people's needs, for example personal care, eating and drinking, mobility and skincare and medication. This information was used to develop care plans to support staff to understand people's choices and how to meet their needs. We found that when peoples' needs or choices changed, this was not always accurately reflected in care plans and staff relied on their own knowledge of people's needs.

● 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

● People's needs were not always met by staff with the relevant knowledge and skills.

● Not all staff had a health or social care qualification or had completed the Care Certificate. The Care Certificate is a nationally recognised induction which covers all the areas considered mandatory for care staff.

●Training methods included, online, shadowing of experienced staff and on the job and competency assessments. We found that staff did not always complete their training. One staff member told us "I have not had training in catheters or safeguarding." Another staff member said, "I do train online, they [Name of deputy manager] are chasing it up but we are not paid to do training, I don't have time to do it."

●Staff told us they had regular spot checks where managers checked their practice. One staff member said, "I've had two spot checks." Records we saw confirmed this.

Supporting people to eat and drink enough to maintain a balanced diet

● Staff supported people with meal preparations and to eat and drink. We heard mixed views from people and relatives regarding dietary support. One person said, "I can't use a microwave, so the carers do my meals. Sometimes I have a plated meal and sometimes a sandwich or cake." A relative stated "The calls are not evenly spaced. Sometimes [name of person] doesn't get their breakfast until 10:30am and then they don't want their lunch until mid-afternoon." Another relative stated, "We leave notes for the carers on what food to give but they just give soup. Food is not being used and is being thrown away."

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● We found examples of staff working closely with other agencies, for example attending visits with occupational therapists to contribute to people's `needs assessments`.

● Staff knew people's needs well and informed the deputy manager of any changes in people's conditions. The registered manager did not always use this information to update care records and risk assessments.
● The RM did not always work in a timely or effective way with other health and social care professionals and relatives. For example, there were delays in making referrals to health care professionals and when referrals were made the provider did not follow up on the outcomes experienced by people.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act 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. We checked whether the service was working within the principles of the MCA.

●The registered manager was aware of their responsibilities under the MCA and care plans included information about mental health and people's capacity to take decisions.
● Staff understood the principles of MCA and how to support people in their best interests. Staff were able to tell us how they asked for people's consent to 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 the last inspection this key question was rated as Inadequate. At this inspection this key question has now remained the same. 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At the 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. At this inspection the required improvements had not been made and the provider remained in breach of Regulation 17.

- The provider had implemented systems 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.
- The provider's systems to monitor safe administration of medication had not identified concerns found at this inspection. For example, MAR charts did not always have all relevant medications recorded and contained incorrect information about frequency of administration. Where contraindications between medications existed, they were not identified.
- The provider's systems to monitor the quality of risk assessments and care plans had not identified concerns found at this inspection. For example, a person was identified as experiencing falls, but the risk was not assessed. Another person was experiencing behaviours that were causing them distress and this was not assessed to keep them safe.
- The provider's systems to monitor recruitment processes had not identified the concerns found at this inspection. For example, we found staff had been recruited without DBS checks and information of concern provided by recruits had not been risk assessed.
- The providers system to monitor staff had the relevant knowledge and skills to support people, had not identified the concerns found at this inspection. For example, we found staff were not always completing their training and training records did not identify the dates of training.

This is a breach of Regulation 17 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; Working in partnership with others

- The provider had not met their duty of candour. Not all incidents were shared with external agencies to ensure people were safe. This meant that relevant agencies were not always informed of incidents of the actions taken by the provider to keep people safe.

Continuous learning and improving care

● The provider had made some improvements to the monitoring systems, since the last inspection. However, we found the monitoring systems were not being effectively used and therefore did not identify areas for improvement within the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

●People and their relatives told us they were asked for their feedback on the care they received. We saw records of completed service reviews. We saw some concerns had been raised but the provider did not keep an audit trail of actions taken and outcomes for people using the service and their relatives.

● Staff told us they took part in meetings and supervisions. One staff member said, "In supervision I raised about the communication, we need more communication, we now have a new manager who is doing their best and gets back to you."

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 Risk assessments did not contain clear guidance to keep people safe. Staff did not have accurate information to enable safe administration of medication. Staff did not always wear personal protective equipment, (PPE).

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Staff concerns for people's safety were not always acted on. Staff were not supported to raise safety concerns and their confidentiality was not always protected. Not all staff had been trained in safeguarding.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were not effective and did not identify areas for improvement within the service.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Checks to ensure staff were safe to work with vulnerable people, were not always completed.

DBS information was not always requested as part of the recruitment process. Where DBS information had been obtained it was not always effectively assessed.