THC Care Ltd

Tipton Home Care Limited

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Tipton Home Care Limited is a domiciliary care service providing personal care to older people with a mixture of needs including dementia and physical disabilities. People are supported in their own homes, at the time of the inspection 121 people were receiving personal care.

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
At the last inspection we found the provider's systems to monitor the quality and safety of the service were not consistently effective. At this inspection we found the required improvements had not been made and the service remained in breach of the regulations.

At the last inspection we found improvement was required where people were supported with 'as required' medication. At this inspection we found this work had not been done.

People did not consistently receive their care calls at the times agreed on their package of care. The system to allocate packages of care was not effective, staff were rushed and frequently had new calls placed on their rota at last minute, making it difficult to meet people's care needs.

People's care records were not consistently reviewed and did not hold the most up to date and accurate information regarding their care needs. Staff were not provided with the most up to date information on how to support people safely and effectively.

Medication management was poor. Staff were not provided with information regarding people's medication and the risks associated with it. Systems in place could not provide assurances that people received their medication as prescribed.

The provider's governance systems had failed to identify and address a number of areas of concern that had been identified on inspection.

People praised the staff who supported them, but felt their concerns and complaints weren't heard or listened and responded to.

Staff felt people did not consistently receive their care as per their wishes, due to an infective call allocation system and poor governance.

The provider had failed to respond to concerns raised and opportunities to learn lessons were lost.

This is the second inspection that THC Ltd has failed to reach an inspection rating of good and the second occasion when a breach of Regulation 17 has been found.

Rating at last inspection and update
The last rating for this service was requires improvement (published 20 January 2020). At this inspection enough improvement had not been made sustained and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about late care visits and medication errors. 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 Requires Improvement to Inadequate. This is based on the findings at this inspection.
We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Tipton Homecare Limited 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 person centred care, safe care and treatment, staffing and good governance.

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

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 six months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe.	**Inadequate**
Is the service well-led? The service was not well-led.	**Inadequate**

Tipton Home Care Limited

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors, an assistant 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.

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 did not have a manager registered with the Care Quality Commission. A registered manager is a person who has registered with the CQC 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.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the provider or manager would be in the office to support the inspection.

Inspection activity started on 21 January 2021 and ended on 25 February 2021. We visited the office location on 10 February 2021. We reviewed records between 17 and 25 February 2021.

What we did before the inspection
Prior to the office visit the inspection team made calls to people who used the service, their relatives and staff between 21 and 25 of January 2021. We reviewed information we had received about the service since

they registered with CQC. We sought feedback from the local authorities who commission packages of care from the service.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection-
We spoke with 27 people who used the service, five relatives and 13 staff, including the provider, the manager and quality compliance officer. We reviewed a range of records to include nine people's care plans, 11 people's medicine records and ten people's call logs. We looked at three staff members files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We reviewed the additional documentation we had requested from the provider, manager and quality compliance manager to validate evidence found.

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

Using medicines safely

● Prior to this inspection, we were made aware by the local authority of concerns regarding medication errors. We found widespread concerns regarding the management of people's medicines.

● At the last inspection improvements were needed for 'as required' (PRN) medication. At this inspection, 17 people had been identified by the provider as needing a PRN protocol to guide staff so they would know in what circumstances the medication should be administered and the risks associated with this. This work remained outstanding which meant staff did not have the information needed to administer these medicines safely and effectively and as prescribed.

● We looked at 11 medication care plans and found they failed to provide staff with information on the risks associated with people's medicines and the instructions to follow to administer people's medication safely and effectively. One person's care plan stated a particular medicine should be given daily instead of weekly. We were informed the care plan had recently been reviewed, but it remained inaccurate.

● Two people required support with time specific medication blood thinning medication. Their care visits were frequently delayed which impacted on the timing of their medicines being administered. Care records held no information for staff regarding the side effects of this medication or the increased risks to people in missing or delaying this medication [a higher risk of blood clots]. This meant there was a risk to people's treatment of their health conditions.

● One person's medication had to be administered at the same time every day [to achieve effective control of the symptoms of Parkinson's disease]. There were nine occasions during a 31-day period when their medicine was not signed for during their lunchtime visit. On three occasions in January 2021 staff had recorded their calls were too late to administer the medication. This put the person at significant risk of harm as their medicines were not administered as prescribed to manage their health condition.

● There was no evidence to show the pain relief patches of three people had been applied according to the manufacturer's instructions and no guidance for staff to follow regarding the correct and effective application of these patches. This meant people were at risk of not receiving their medication for pain relief safely and as prescribed. We saw the manager had raised safeguarding concerns on two occasions where people had not had their prescribed pain patch.

● People and relatives highlighted the negative impact of poor medicine practices which for some people meant they did not get their medicines when they needed them. A person told us, "They are very late sometimes and this impacts on my pain relief which I need staff to help me with." Another person said, "I have to take my tablets with food, so I miss my morning tablets when they come late." A relative told us, "Sometimes the morning call is before 8.00am but today it was 10.00am. (Name) is lay in bed waiting, not up and not eaten and so late having medication."

● We saw numerous gaps in Medication Administration Records [MAR] for those people who required

support with the application of prescribed topical medicines. Body maps were not in place to provide clear direction where topical medicines should be applied. For example, one person's [which should have been applied twice daily] were only applied 10 times during the morning call and 24 times during the evening call during at 31-day period. Staff told us they did not consistently apply topical medicines when calls were running late.

● The provider had completed only three medication audits in twelve months; January 2020, March 2020 and October 2020, in which MARs were reviewed for a total of eleven people. Audits showed there was a consistent theme of MAR's not being signed to indicate people's medicines were administered as prescribed. The audits did not capture the medicine errors we identified at this inspection.

● The manager acknowledged there were significant concerns over the volume of medicine errors and poor records. She was prioritising safe medicine training for all staff which we saw had commenced. She had removed staff from medication duties where errors had occurred.

We found people were at risk because staff did not administer medicines in a timely manner and people did not receive them as prescribed. Safe medicine practices were not promoted and record keeping was inconsistent and at times incomplete. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● Care plans and risk assessments in place did not detail the support people required. One person's care plan was dated 2017 and stated they had one call a day for 30 minutes. Their family told us, and call logs confirmed, they received three calls a day; there was no assessment or care plan in place to guide staff in providing care for the additional two calls a day.

● A second person was assessed by the occupational therapist regarding their mobility needs and had new equipment in their home. A reassessment of their needs had not been completed and the care plan not updated to ensure staff had information on how to support the person safely with new equipment.

● Where people had specific health conditions such as diabetes or Parkinson's disease, there was no risk assessment or written guidance for staff on how to support people with these conditions and no information regarding the risks related to them. Some staff we spoke with were not aware of symptoms someone with diabetes may develop, or the symptoms someone with Parkinson's may experience.

● Not all staff we spoke with were aware of people's health conditions and how to manage risks related to these. Some staff told us some care plans and risk assessments were illegible or not evident in people's homes to provide guidance.

We found people were at risk as staff were not provided with the most up to date information regarding people's care needs and how to support them safely and effectively. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● Staff did not consistently apply effective infection control measures. Some people told us staff did not always use personal protective equipment (PPE) effectively. One person said, "A hole appeared in the carer's glove when they were creaming me, but they didn't stop and change it." Another person said, "They [care staff] were lowering their masks and I had to tell them to cover their mouth and face."

● We found staff had not had their competency assessed to evidence they were following infection control procedures.

● We found there were no individual risk assessments relating to Covid-19 for people using the service to assess any increased risk. Some staff at increased risk of COVID-19 due to underlying health conditions had been furloughed.

● We found there were no risk assessments related to Covid-19 in place for pregnant staff. The staff member responsible for these was not aware of the risks to pregnant women after 28 weeks gestation. We were advised this would be addressed once they had confirmed the stage of pregnancy.

People were placed at risk as the service did not consistently follow or meet national guidance in relation to infection control. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff we spoke with told us they had Covid-19 infection control training and had received guidance on how to safely use personal protective equipment (PPE), including donning and doffing of PPE.

Learning lessons when things go wrong

● We saw records were kept of complaints and safeguarding incidents. Whilst these were recorded and action taken to resolve individual concerns, there was no analysis of trends or patterns identified, or evidence of learning from events. Therefore, there were repeated incidents, safeguarding concerns, complaints about late calls and medicines errors.

The provider had failed to ensure that lessons were learnt from concerns, accidents, incidents or adverse events. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager had identified some immediate actions such as medicine training for all staff to improve safety across the service.
● The provider told us they had a recruitment drive that would address their staffing difficulties.

Staffing and recruitment

● The system in place for allocating care calls was ineffective. People did not consistently receive their calls at the agreed time to meet their care needs effectively and safely. An audit dated January 2021 compared expected call times with the actual call times received and identified hardly any were correct.
● We reviewed call logs for ten people and saw calls were frequently late and, in some cases, excessively late and not for the full duration of time. For one person over a 10-week period only one of their calls was on time, several calls were short and some either two hours late or two hours early.
● Several people told us carers had come to their home at 6pm to put them to bed; one person told us being put to bed earlier would mean a longer period in bed until their morning call at 8am, increasing the risk of experiencing pain and discomfort. Another person was most distressed at a call to their home at 11.30pm which had upset and worried them. The provider had failed to take into account the impact of this failure to provide a service that met people's needs and preferences.
● Complaints records showed one person had 13 different carers support them over a five-day period. Their care was not planned or delivered in a way that had considered their individual needs and circumstances. People were not always given advance notice of late calls or that a different carer would be attending to them. The provider told us, "Staff work in pools. We'd be on the phone all day if we had to tell people that we had to change their carer." This showed people's preferences were not consistently met or considered.…..
● Rotas were planned weekly, but staff were given the opportunity on a daily basis to hand calls back, meaning calls had to be covered by other members of staff at short notice. A member of staff told us, "I've had to pick up calls at midnight; as the morning call has been so late it's impacted on the rest of the day and to make sure they have the gap between medicines." They told us this was not an unusual situation and staff who were having to walk to different calls were refusing to walk that late at night, for fear of their own safety.

● The provider had failed to ensure staffing levels were reviewed and sufficient staff were deployed to meet people's needs. The poor organisation, lack of consistency in carers and continual lateness of calls meant that people who used the service could not be confident the provider ensured they received person centred care and treatment that was appropriate, met their needs and reflected their personal preferences.

We found the provider had failed to ensure people who were in receipt of a service received person-centred care and treatment that met their needs and reflected their personal preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 Regulations 2014). The care and treatment of service users must be appropriate, meet their needs and reflect their preferences.

● Staff had been recruited safely. All pre-employment checks had been carried out including reference checks from previous employers.

Systems and processes to safeguard people from the risk of abuse

● At our previous inspection on 4 & 10 December 2019, the provider had not alerted the local authority about restrictions to people's liberty. This was a breach of regulation 13 (Safeguarding service users form abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities). At this inspection we saw the provider had acted to comply with this regulation.

● The majority of people told us they did feel safe with the carers. Comments included; "I've got confidence in the carers; they are excellent". Another person told us, "I feel safe, the carers are good".

● Staff told us that they felt people were safe although some people experienced delays in their care which impacted on their comfort or safety. A relative told us how delays in the morning call meant their family member waited long periods from the previous night to have their continence needs met. This could put them at risk of skin damage or pressure wounds. They told us things had recently improved.

● Staff told us they had received safeguarding training. Staff recognised their role in protecting people from harm or abuse and knew how to escalate their concerns. This was confirmed in records we saw held by the provider, for example, the quality concerns tracker contained information and action taken about concerns observed by staff.

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 found the provider had failed to have effective governance systems in place to monitor the quality of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This inspection found further improvement was required and the service remains in breach of regulations.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- We found areas requiring improvement at the last inspection on 4 December 2019 had not been addressed. The provider remained in Breach of Regulation 17 because they continued to fail to operate an effective system of audits or establish robust processes to ensure full compliance with the requirements of the regulations.
- The lack of robust governance systems in place meant the provider failed to identify and address issues that came to our attention during the inspection. The provider advised that many of their audits and processes had not been completed due to a staffing crisis at the service between the months of October and December 2020. However, we found a variety of audits, including staff competency checks had not taken place prior to this date.
- Governance processes continued to fail to identify care plans and risk assessments did not hold the most up to date information regarding service user's individual needs, as found at our last inspection. Further, care plans for people with specific health conditions such as diabetes and Parkinson's disease were not in place to guide staff in how a person's care needs should be met. This meant people were exposed to the risk of harm as their care needs and risks associated with their care were not identified, recorded or shared with care staff.
- Audits of Medication Administration Records [MAR] were not taking place. MAR charts were not always completed and signed to indicate people had received their medicines and at times hadn't been administered as prescribed. This meant the provider had not assessed people were not receiving their medicines as prescribed. People told us they often did not receive their medicines at the times prescribed or when they needed them.
- Governance processes had failed to ensure call planning systems were safe and effective. People consistently received calls at the wrong time and a high volume of complaints regarding call times had been received. We found no evidence that the information from these complaints was being acted on or used to improve the service. The Provider told us they and a care co-ordinator were responsible for the rotas. They told us, "I roster different to [care co-ordinator's name], that is the problem." They had taken no action to address this discrepancy.

● The provider had continued to take on an additional 12 packages of care, during October, November 2020 and January 2021 despite informing us on 30 October 2020 that they had critical staffing levels and were struggling to support existing service users. The provider told us the packages of care were picked up to replace those that were lost, and that their recruitment drive in January had been positive and enabled them to manage the care calls. However, we found evidence that people continued to receive a poor level of service with regard to the timing of their calls.
● Governance processes had failed to ensure that actions were taken to implement Government Guidance COVID-19: how to work safely in domiciliary care were effective. There were no Covid-19 risk assessments on service user files. Risk assessments were in place for pregnant women but did not take into consideration the additional risks to them after 28 weeks of pregnancy. We spoke with the HR manager who was not aware of this guidance.
● People and relatives we spoke to told us they were not assured their concerns would be addressed, or if they were, would not be sustained. This was evidenced in the provider's quality concerns matrix. We saw although people had been contacted when they raised concerns, people had continued to complain about the same issue as it had not been resolved.
● People who used the service told us they did not feel listened to; they told us they could not always get through to the office as no one answered their calls, and the issues related to call times were not resolved. They felt they did not have continuity or consistency because of the constant changing of staff.
● Shortfalls had been highlighted to the provider from our previous inspection in December 2019. We found at this inspection action had not been taken to address those issues and improvements to the service had not taken place. This is the second consecutive inspection that THC Care Ltd has failed to reach an inspection rating of good; of the two inspections this is the second occasion when a breach of Regulation 17 had been found.

The Provider had not ensured there were adequate systems to monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The Provider is required to ensure there is a manager registered with the Care Quality Commission who is in day to day control of the service. The provider had recruited to this post and aimed to submit an application to be registered with the commission.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The manager was new in post and told us she had plans to consult with all staff and review all job descriptions. She had identified additional roles that needed to be filled and had spoken with the provider regarding this. She had identified improvements that were needed based on managing risks and staff performance and support. This would better enable the manager to monitor the staff team and ensure the delivery of good care, however, an action plan was not in place.
● The manager shared with us some progress on delivering safe medicines training and manual handling training to staff. She was reviewing medicine management, care records and safeguarding. We did see evidence of proactive leadership in terms of the actions she was taking when risks were being identified, for example, removing staff from medicine duties when errors were being made.
● Staff told us they did not feel valued because when they raised concerns about care call timings, 'nothing changed'. Some staff did not always feel safe; walking to calls very late at night due to over-run calls.
● All staff spoken with told us they felt people did not have good outcomes or person-centred care because the time spent with them had reduced due to call cramming.

● People who used the service were very complimentary about care staff, stating how hard they worked and how nice they were.

Working in partnership with others

● The service worked in partnership with two local authorities who commissioned care and support for people. The provider had alerted commissioners in November 2020 to a disruption in service due to critical staffing levels. Commissioners told us there had been a lot of safeguarding concerns related to missed calls and medication errors. They said they had remained in contact with the provider who had advised them he intended to take on more packages of care as he was recruiting new staff.

● Another professional expressed concern regarding a regular care call to their client which had been cancelled by the service and they had not been informed about. They had had no communication regarding this which meant the person had been without one of their visits from March 2020 to January 2021. This did not demonstrate the provider worked in partnership to support care provision.

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; Continuous learning and improving care

● We found no evidence the service had learnt from complaints concerns or incidents. Records of these were available but did not include an analysis for trends or patterns that would enable the provider to improve quality. We saw no evidence of people being provided with assurances of improvements in the level of their care. The provider's complaints records showed repeated complaints about call times and call cancelling due to lateness.

● The provider had failed to effectively monitor the service's performance and ensure that high quality care was provided. Their quality compliance officer had maintained records on aspects of the service and had identified significant on-going issues with the service's performance prior to this inspection. Action was not evident as to how the provider was addressing these quality issues.

● During the inspection we discussed an incident with a five-hour delay in a person's call, resulting in the person cancelling their call. We had to prompt the provider to carry out an investigation for the reasons for the delay in order to learn lessons and reduce the risk of reoccurrence.

● People who used the service told us they had lost confidence in the service. Some reported poor communication, poor organisation and poor leadership.

● We found the provider reported incidents of missed calls and sent safeguarding alerts to the local authority in line with their policy.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people who were in receipt of a service received person-centred care and treatment that met their needs and reflected their personal preferences.

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 We found people were at risk because staff did not administer medicines in a timely manner and people did not receive them as prescribed. Safe medicine practices were not promoted and record keeping was inconsistent and at times incomplete. We found people were at risk as staff were not provided with the most up to date information regarding people's care needs and how to support them safely and effectively. People were placed at risk as the service did not consistently follow or meet national guidance in relation to infection control.

The enforcement action we took:

We issued a notice of proposal to impose positive conditions

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The Provider had not ensured there were adequate systems to monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people.

The enforcement action we took:

We issued a notice of proposal to impose positive conditions.