THC Care Ltd

Tipton Home Care Limited

Inspection report

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

Tel: 01213140327

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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
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 92 People were receiving personal care.

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 been made.

Governance systems were now in place that provided oversight of the service. Accidents, incidents and matters of a safeguarding nature, were responded to and acted on appropriately. Analysis of this information was taking place to identify any trends or lessons to be learnt.

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 been completed and people's medication care plans had been reviewed and updated. Medication management had improvement and an electronic monitoring system was in place to ensure people received their medication as prescribed.

Improvements had been made to the systems in place that allocated packages of care. An electronic system was in place which enabled office staff to monitor call times and on the whole, people received their calls at the agreed times. In response to unexpected staff absence, the provider and manager worked proactively to ensure people received their calls.

People's care records had been reviewed and held the most up to date information regarding their care needs. Staff reported they were kept up to date with changes in people's care needs in a timely manner.

People were complimentary of the staff who supported them and felt safe when supported in their own homes.

Following the last inspection, the manager had focussed on addressing risk and ensuring staff received the training and support they needed. Staff reported improvements in the governance of the service and felt supported and listened to.

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 7 June 2021) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made and the provider was no longer in breach of regulations.

This service has been in Special Measures since June 2021. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
We carried out an announced inspection of this service on 10 February 2021. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve in response to the following breaches; safe care and treatment, person centred care and good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe 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 in calculating the overall rating at this inspection. The overall rating for the service has changed from Inadequate to Requires Improvement. 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 Tipton Home Care Limited on our website at www.cqc.org.uk.

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 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 always safe.

Requires Improvement

Is the service well-led?

The service was not always well led.

Requires Improvement

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 one inspector, an assistant inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for some 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 and specialist housing.

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 of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Notice of inspection
We have the service 24 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 8 September and ended on 8 October 2021. We visited the office location on 8 September 2021. We spoke with staff and people who used the service on 30 September 2021 and 1 October 2021. We reviewed records and information sent to us between 5 and 8 October 2021.

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 and professionals who work with 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.

During the inspection
We spoke with nine people who used the service and 14 relatives about their experience of the care provided. We spoke with eleven members of staff including the provider [who is also the nominated individual and a director], the manager, care co-ordinators, field care supervisors and care workers. We reviewed a range of records to include nine people's care plans, medicine records and 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 minutes of meetings, audits and action plans.
The nominated individual is responsible for supervising the management of the service on behalf of the provider.

After the inspection
We reviewed additional documentation we had requested from the provider to validate evidence found.

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 inadequate. At this inspection this key question has now improved 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.

Using medicines safely
At our last inspection 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 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

- Medication care plans were in place which provided staff with information on the risks associated with people's medicines and instructions to follow to administer medicines safely. Protocols were in place to guide staff when supporting people with 'as required' medication and body maps were in place indicating where pain relief patches and creams should be applied.
- An electronic medication recording system had been introduced which enabled staff to immediately report when they had supported a person with their medication. A member of care staff told us, "It's much improved [the service] since using EMAR [electronic medication system], I'm finding it a lot better" and another said, "We have to give four hours between all medications and we check on our app to make sure."
- Since the last inspection, staff had been retrained in supporting people with their medication and had had their competencies assessed in this area. A member of staff told us, "[Manager's name] did the training in the office and I felt confident when I came out."
- Care co-ordinators who were responsible for the allocation of calls, were aware of those people who required support with their medication at specific times of the day and systems were in place to ensure these calls were always completed as a priority.
- Systems were in place to ensure medication audits took place in real time. The electronic medication system alerted office staff if a member of care staff had failed to record a person had received their medication, following a call. This prompted care co-ordinators to immediately contact the member of staff to ensure medication had been administered as prescribed. We observed where one such incident was followed up, care staff reported that a relative had already administered the medication, prior to the call.

Assessing risk, safety monitoring and management
At our last inspection 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

● The majority of care plans and risk assessments had been reviewed to provide staff with the most up to date information regarding people's care needs. At the time of inspection, four care plans remained outstanding and work was underway to complete this work. Staff spoken with confirmed care plans and risk assessments were up to date and much improved. A member of staff told us, "As soon as care plans change you need to read them straight away, even if you've been supporting someone for years. Information has definitely been added." Another member of staff told us, "I'm aware care plans have changed, we have been involved and checked to see everything was in there; it is pretty good and gives you all what you need to know."
● We saw the manager had identified an additional risk assessment was required for one person, however this work was not completed in a timely manner, resulting in a complaint being received which highlighted that a member of staff was not aware of the additional risk to the service user. The provider responded immediately to the concerns raised to ensure the risk assessment was updated and staff were made aware of this change in need.
● Although improvements had been made to care plans and risk assessments, it was recognised that this was a work in progress and the changes being made required embedding into the current systems and processes.
● Risk assessments were in place for specific health conditions, providing staff with information on actions to take if a person showed signs of becoming unwell, for example a person living with a diagnosis of diabetes.
● Staff spoken with were aware of people's healthcare needs and how to support them to access healthcare services.

Preventing and controlling infection
At our last inspection we found 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

● Every person and relative we spoke with told us staff wore appropriate PPE [personal protective equipment] when supporting them, bar one. One person said, "Yes, they are still wearing the masks" and a relative told us, "Yes, they [care staff] wear them [PPE] and put them in the bin outside." Another relative commented, "90% of the time they are wearing masks, but I know one person is exempt from wearing a mask".
● Following a number of staff receiving positive COVID-19 test results, the provider had instructed staff to re-commence wearing face shields as well as masks, in order to reduce the risk of the spread of infection. Staff and people using the service confirmed this was the case.
● Staff had received guidance and training with regard to the appropriate use of PPE in line with the latest government guidance. Staff confirmed there were plenty of supplies of PPE available to them.
● There were systems in place to monitor staff compliance with wearing PPE appropriately and in relation to staff testing.

Learning lessons when things go wrong
At our last inspection 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

● Lessons were learnt when things went wrong. Accidents, incidents and safeguarding concerns were all dealt with on an individual basis. Analysis of this information took place to identify any lessons learnt or trends. For example, we saw that staff had identified a person at risk of suffering from sore skin and appropriate action was taken and followed up to ensure district nurses visited the person.

Staffing and recruitment
At our last inspection 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 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9.

● People confirmed that on the whole, their calls were on time and staff stayed for the correct amount of time, unless people asked them to leave. A call monitoring service in place enabled care co-ordinators to monitor calls and the majority of people spoken with told us they had been contacted if a call was running late. One person told us, "If there is a problem, they have always communicated well."
● Recent analysis by the provider had identified an improvement in call times, but these figures had been affected due to some staff absence. This meant for some people, their call times were not consistently delivered on time and some were not informed of the changes. We observed action was taken to ensure calls were met by care staff who knew people. One person told us, "On Sunday, [provider's name] came out to our house and he was a very good carer. I know they are having problems with staffing because of COVID-19, but they made sure we had care and did everything they could to make sure we had someone we knew when they came in."
● Staff spoken with confirmed rota allocations had improved. One member of staff told us, "It was a nightmare [previously], but it seems to be getting better, they'd just add calls to your rota without telling you, now they are more organised and will ring and ask you first. If I can help out I will. I always do."
● We looked at the personnel files of three members of care staff. Appropriate checks including obtaining references and Disclosure and Barring Service checks [DBS] had been completed prior to staff commencing in post.
● The provider talked of the challenges they faced recruiting staff to the service. Recruitment drives were in place to attract more staff to the agency and staff absence was currently covered by existing staff. We observed the provider and manager work proactively to ensure all calls were covered when faced with unexpected staff absence.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe when supported by staff in their own home. A relative commented, "Oh yes, [person is safe] they're great, they know her really well and if they notice anything out of the ordinary, they tell us straight away."
● Staff were aware of their responsibility to raise and act on any concerns that came to their attention. Safeguarding concerns were raised appropriately and action was taken in response to each event.

● The electronic recording system that had been introduced by the Provider ensured staff were able to raise any concerns in a timely manner, providing office staff with the information required to report and act on information received.

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 inadequate. At this inspection this key question has now improved to requires improvement. 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

At our last inspection 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17.

- A number of quality assurance systems were now in place to give the manager and provider oversight of the service. The provider acknowledged this was an ongoing piece of work which was still being developed and needed to be imbedded into the day the day running of the service
- Changes to staffing structures had taken place and staff were clear of their roles and responsibilities. This resulted in improvements in office management and the completion of audits. However, it was acknowledged that responsibility to review all care plans in a timely manner had been a large task for one single member of staff and had resulted in the delay of one person's risk assessment being completed in a timely manner. The provider advised they would be reviewing office staffing levels when more packages of care had been taken on.
- An electronic monitoring system was used to assist in call monitoring and the recording of medication administration. Plans were in place to develop the system to record care plans and risk assessments.
- People's care plans and risk assessments had been reviewed, with four outstanding at the time of the inspection.
- The impact of staff absence and outbreaks of infection of COVID-19 amongst staff had created challenges in the service, but staff told us they had felt better equipped to deal with the concerns.
- The provider was taking a more proactive approach in the running of the service and we observed them working closely with the manager and care co-ordinators to ensure calls where covered when last minute absence took place.
- Staff had received training in supporting people with their medication and had their competencies assessed. Medication Administration Records [MAR] were audited in real time and appropriate actions taken where necessary.
- The provider was actively looking to recruit to lessen the burden on existing staff, but had also confirmed

that they were concerned for the coming months and winter pressures and had committed to not taking on any more packages of care during this period to ensure they could meet the care needs of the people they currently supported.

● People and relatives told us they felt more confident in the service and had seen an improvement in care delivery and call times. People acknowledged there had been 'blips' in call timings but confirmed they understood the reasons why [unexpected staff absence due to COVID-19] and that the provider had kept them informed. The majority of people spoken with told us they had been made aware if a call was running late and no one had experienced a missed call.

● The quality assurance audits in place had highlighted where improvements in the service were required and an action plan was in place to address any concerns.

● 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 the manager had submitted 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

● Surveys had been sent out earlier in the year to staff and service users, asking for feedback on the service. The information was analysed, but further work was required to review the feedback received. The provider was in the process of sending out more surveys and confirmed they would be reviewing the information received and acting on any concerns raised.

● Since the last inspection, the manager had worked hard to ensure staff received the training and support they required to carry out their role. Staff spoke positively about the manager and found her supportive and approachable. All staff had been re-enrolled on the care certificate training and had been offered additional support where required. For example, a number of staff were supported to access their learning materials using computers in the office, with the manager being on hand to offer any further guidance.

● Staff told us they felt morale had improved since the last inspection and they felt listened to. They told us the introduction of the electronic recording systems had made a big difference to how they worked and that communication between themselves and office staff had improved greatly. Staff acknowledged there was still work to do and ensuring all calls were covered remained a constant source of concern. However, they confirmed that management on the whole, contacted them prior to adding calls to their rota and they were keen to help out as much as they could. They also acknowledged that the provider, manager and care co-ordinators had also stepped in to cover calls following unexpected staff absence.

● People and staff told us they were happy with the service and considered it well led.

● People who continued to use the service were very complimentary of the care staff who supported them, and we received numerous comments of this nature. For example, one person told us, "The girls [care staff] are all lovely, I don't have any problems with staff" and a relative told us, "Oh yes, they're great, they know [person] really well and if they notice anything out of the ordinary they tell us straight away."

Working in partnership with others

● The service worked in partnership with two local authorities who commissioned care and support for people. Following a recent quality monitoring visit from the local authority, the quality assurance officer confirmed they had noted improvement in the governance of the service.

● The serviced worked alongside a number of healthcare professionals in order to ensure people received appropriate care. The service had raised concerns when they were struggling to meet calls and had contacted local authorities for assistance.

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 evidence that the provider learnt from complaints, concerns and incidents. We saw incidents were reported in a timely manner and acted on appropriately. Analysis of this information took place to identify any lessons to be learnt or identify any trends that required action.

● The provider was open and honest during the inspection and took on board feedback given.