

Tabitha Home Care Limited

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Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Good ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

The inspection took place on 05 and 07 June 2018 and was announced.

Tabitha Homecare Ltd provide care to people in their own homes. Approximately 187 people were in receipt of personal care at the time of our inspection. This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community.

When we last inspected the service in September 2017 we rated the service Good overall with Requires Improvement in Well led. At this inspection, some of the improvements we recognised last time had not been sustained and further improvements required were identified.

A registered manager was not in post and had left shortly before this inspection. 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. The service was managed by a director of the service.

People felt safe with staff in their home who they knew and felt comfortable to be with. Staff understood how to report concerns to the office based staff who would follow up their concerns.

Risks assessments were completed for staff to refer to and these had been reviewed and updated where appropriate. The registered provider had begun the process of electronically monitoring calls although this was not embedded across all of the service, people were not consistently experienced calls at their agreed time. Staff recruitment included background checks so the registered provider understood if staff were suitable to work at the service. Where a person's needs had changed the information was shared with staff so they were able to implement changes where needed.

People were supported by staff that had access to supervision but their training was not always planned to ensure they received it in a timely way. Staff had not consistently received training to maintain their skills and knowledge support people with their medicines in a safe manner.

People were supported to maintain a healthy diet through the choices of meals and drinks staff offered them. People were supported to access support from healthcare professionals where this was appropriate. People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

People knew and liked the staff supporting them because they saw staff regularly. People made decisions about their day to day care. People were treated with dignity and respect. Staff understood what it meant to individual people in terms of maintaining their dignity.

People were involved in discussions about planning their care. People understood how to complain and understood the process for doing so. The registered provider had a system in place for recording communication with people however so that concern were responded to. However, concerns were not always investigated to understand the causes of complaints so that trends could be identified.

The registered provider's system for reviewing and improving people's experience of care could not always be evidenced. Staff training had not been monitored to ensure training was up to date. Negative feedback received had not been analysed to ensure trends could be monitored to prevent any repeats.

Whilst staff were positive about their feedback about the registered provider, it was not clear how systems were embedded to continually improve people's experience of care. There were also missed opportunities to improve people's care through better relationships with training providers.

Further information is in the detailed findings below.

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.

People were supported by sufficient staff and call times were monitored, however, some people had experienced call times later than planned.

People told us they felt safe supported by the staff who knew how to keep people safe from harm. People were supported by staff to take their medicines, however not all staff had had their training updated to support people with their medicines. Learning gained from people's care was shared with staff to prevent reoccurrences of any incident.

Requires Improvement ●

Is the service effective?

The service was not always effective.

People were supported by staff whose access to training and supervision was not planned so that staff received their training in a timely way to maintain their skills and knowledge.

Staff knew about the importance of obtaining consent before providing care. People were supported to make choices about the meals and drinks staff provided. People were supported to access external health professionals to support their wellbeing.

Requires Improvement ●

Is the service caring?

The service was caring.

People's needs were met by staff who they knew and liked and who they saw regularly. People were treated with dignity and respect and supported to maintain their independence where possible.

Good ●

Is the service responsive?

The service was not always responsive.

People were supported so that they received care that was in response to their circumstances. People understood how to

Requires Improvement ●

complain if they needed although the system for managing complaints was not always understood by staff and applied consistently to promote a cultural of learning and improving.

Is the service well-led?

The service was not always well led.

The registered provider was not able to demonstrate how they checked to ensure people received good quality care.
Partnership working had not always worked effectively so that information was shared to better promote people's care

Requires Improvement ●

Tabitha 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.

Inspection site visit activity took place on 05 June and 07 June 2018. The visit to the office was to speak with the registered manager and other office based staff as well as to review care records and other documents. We made telephone calls up until and including 20 June 2018. The inspection team consisted of one inspector.

We gave the service 48 hours' notice of the inspection visit because we needed to be sure that they would be in.

We reviewed the information we held about the service and looked at the notifications they had sent us. A notification is information about important events which the provider is required to send us by law.

During the inspection, we spoke with nine people and three relatives of people receiving support. We spoke with four members of staff, a director of the company as well as the registered provider. We looked at aspects of 10 people's care records and medicines records. We looked at staff rotas, compliments and quality checks completed on behalf of the registered provider.

Is the service safe?

Our findings

We last inspected this service in September 2017 and rated this section as Good. At this inspection we found the system for ensuring practices were Safe, were not always robust. This was because checks needed to ensure staff were competent to support people with the medicines were not in place. Not all staff had received updated training.

Some of the people who used the service and their families that we spoke with told us their relatives received support with their medicines. People that received this support were positive and told us they received the support they needed. We also reviewed people's Medicine Administration Record [MAR] charts. These detailed the medicines people needed and how often they were required. The registered provider accepted that previous MAR charts did not contain sufficient information to guide staff correctly. The registered provider told us they had recognised that the MAR records required more detailed information and showed us the new MAR they would use which they had developed. New charts were being piloted and the registered provider was working with the local authority to ensure MAR charts were robust in how information was being recorded.

However, we saw that checks the registered provider made did not always include competency checks on staff or a review of their training. We saw staff medication training was not up to date and it was not clear when the training had been arranged for. We reviewed Best Practice issued by NICE (National Institute for Clinical Excellence) and saw that Registered Providers were expected to review staff competency for supporting people with their medicines at least once a year. There was a risk that people would not get the support they needed. The registered provider agreed to include this as part of future reviews and to ensure all training was up to date. When we spoke to staff after our visit to the office having identified concerns to the registered provider, staff confirmed they had since attended training.

At our previous inspection we identified that some people had experienced late calls. At this inspection people told us that more recently this had improved and for the majority of the time the correct number of staff arrived at the agreed times. One person told us, "I haven't been let down yet." Another person told us they required two people to support them because they required a hoist to move, and they told us two staff always attended each call. They told us they had "Two carers all the time." People we spoke with told us if their call was expected to be late a staff member would call them and inform them. Some relatives we spoke with told us there were, on occasions late calls, but they felt assured staff would attend because they had regular care staff who they were in contact with. One relative told us when staff arrived late this meant their family member did not always get to the bed at the time they preferred. The registered provider explained they had introduced a call monitoring system but that this was not fully operational across all of their service because they had had some problems with ensuring all people had the system at their home.

Staff we spoke with told us some of the late calls had been caused because there had been a number of staff leave the provider's employment and office based staff were used to cover calls. They also told us that within some areas there were difficulties in retaining staff because of their location. The registered provider told us that overall they had enough staff to meet people's care and support needs however recognised

there had been pressures in some geographical areas. Staff recruitment was on-going to address this issue. They also told us that office staff had undertaken training to enable them to cover care staff shortages.

We saw the registered provider had a system in place for recruiting staff that included a Disclosure and Barring Service check (this check helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups). We reviewed three staff files and saw references and background checks had been completed prior to the staff commencing work with the service. The registered provider was supported by a human resources manager that ensured the necessary checks were in place. We also saw checks the registered provider completed on the staff files to ensure all the necessary paperwork for staff was in place.

The registered provider told us they reviewed people's care and shared with staff any learning that staff needed to be aware of. They told us this was completed through group text messages that were sent out to staff. We spoke with the care-co-ordinators who told us about some of the examples they shared with staff such as a person had requested a staff member not to return and this had been shared with staff.

We reviewed ten care plans and saw risks to people's health were listed for staff to refer to. People's medical histories were also listed that detailed relevant information staff needed to know about a person. We saw where people lived with diabetes, this was included in the information staff needed to know. We saw that plans had been reviewed and updated were relevant and changes made. Staff we spoke with could explain to us how people required support to keep them safe. Staff could describe to us the health conditions people lived with and what support was needed to keep people safe.

The registered provider had a system in place for learning lessons went things went wrong so that people's care could be improved. We looked at a review of concerns that had been shared with the registered manager and saw that the registered manager had completed an investigation and updated staff about the learning from that incident.

Staff we spoke with told us they had access to aprons and gloves and were expected to wear a uniform. Staff we spoke with told us they understood how to minimise the spread of infection.

Is the service effective?

Our findings

We last inspected this service in September 2017 and rated this section as Good. At this inspection we found staff training had not been monitored and identified a need for improvement.

Although people and their families felt confident about how they were being supported by staff, the registered provider did not have a system for ensuring staff training was monitored to ensure it was up to date. Staff we spoke with told us training was not always planned and organised well. This meant that they did not receive their training in a timely way. Some training required updating periodically to ensure staff training support to people was correct and in line with guidelines and best practice.

When we reviewed the provider's training matrix used to oversee when training was due, we saw staff training was overdue for a number of staff. It was also not clear when staff training had been organised. We saw on the training matrix, of 52 staff, only 15 staff had Moving and Handling training that had been updated after their induction. We spoke to people, some of whom were supported to use a hoist, who told us they were confident with the staff that supported, however we could not be certain that the support used was correct. We also saw that only 23 staff out of 52 had received up to date Infection Control training. There was a risk that people's care was not based on best practice.

We reviewed training during and after staff induction and saw staff experience was different. A care co-ordinator we spoke with told us all new staff completed induction training. They told us during this time new staff 'shadowed' (worked alongside) other more experienced staff to understand how to support people correctly. Staff we spoke with told us staff on induction had a different experience of staff training than those who had been with the service for a while. New staff we spoke with told us they received training and support to care for people whilst on their induction. People told us they felt confident that staff supported them appropriately. One person told us they felt staff knew what they were doing. They told us, "They do know what I'm doing. I can tell them. I can tell them if my tops not comfortable. I feel confident that I can talk to them."

Staff we spoke with told us supervision meetings were undertaken. These were one to one meetings with their line manager to discuss their training and development needs and any issues related to work. One staff member we spoke with told us they received supervision "Every three or four months." People we spoke with also told us that staff were sometimes accompanied by office based staff who were there to check staff carried out the tasks correctly.

People using the service had a range of different ethnic and religious backgrounds. We saw and spoke with staff that also had shared backgrounds. The registered provider explained they provided care that was about supporting the person's wellbeing and helping to protect their human rights so that they were not disadvantaged when receiving care. For example, one relative told us about a person's religious beliefs and how it was important their family member received personal care from a person of the same gender. They confirmed that the service respected and accommodated this.

People told us they were supported to maintain a healthy lifestyle that included a varied diet. People told

us when staff helped prepare meals, they were offered choices in the meals staff warmed up for them. People told us they were always offered drinks and staff always ensured they had a drink or a snack before they left.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular 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 particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People told us staff supported them to make decisions about their day to day care. Some staff we spoke with told us, although they had not received training recently, they understood the principles of the MCA. One staff member told us if they were concerned that a person was not able to make decisions for themselves, they would involve their family or speak with their GP as well as speaking to the registered provider. The registered provider told us they did not have anybody they supported at present that was supervised by the Court of Protection but understood the process if they were. Care staff understood how to care for people in line with legislation and guidance.

Is the service caring?

Our findings

We last inspected the service in September 2017 and rated this section as Good. At this inspection this service remains Good.

People told us staff were caring and they liked the staff supporting them because they had got to know each other well. One person told us, "They're wonderful. They can't do enough for you." Another person told us, "I don't regard them as carers. More like friends." People told us they appreciated the staff supporting them and the way in which they were supported. Staff we spoke with could tell us about how people preferred to have their support delivered. For example, staff told us they always phoned a person if they were running late because they became anxious.

People and their families that we spoke with told us staff chatted to them and always included them in making decisions about their day to day care. For example, one person told us how staff checked with them about what clothes they wished to wear and staff ensured they were hung ready for them as they preferred. Staff we spoke to came from a number of diverse ethnic backgrounds and were able to support people with specific language and cultural needs. One family member told us their relative appreciated that they could speak to staff in their first language. They felt most confident that staff understood them when they expressed their care needs.

Staff we spoke with understood what it meant to support people to maintain their dignity and privacy. Staff gave us practical examples such as closing doors and ensuring people knocked on the door if people were in the bathroom. They also explained to us what it meant to promote people's independence. For example, one staff member told us a person liked to do as much of their personal care as they were able to but liked the staff member there for reassurance.

Is the service responsive?

Our findings

We last inspected the service in September 2017 and rated this section as Good. At this inspection we found the service had improvements to make in how they reviewed and noted complaints in order to drive improvement in the service.

People we spoke with told us they felt able to speak with staff about any complaints they may have or they called the office. One person we spoke with told us they had complained in the past about having inconsistent staff, and since then things had improved for them. Another person shared with us that they had been unhappy with one of the staff and that after the complaint, the staff member had not returned to their home.

We spoke with the Registered Provider about their complaints system. They told us they had two complaints they were currently investigating and responding to. However, when we reviewed the complaints, we saw that there were a number of complaint records that were still open and it was not clear whether they were resolved or not. Of the 86 records shown to us, six were marked down as closed. There was a risk that people's concerns were not being responded consistently so that learning from complaints was understood in order to improve the service.

When we reviewed the communication between people and the registered provider, we saw there were a number of occasions when people had complained about the times of their calls or they had called to enquire when staff would arrive. We saw from the communication that all people had been responded to. However, what wasn't clear was the learning gained. For example, one person called and asked for a change in their call time. The response on the record read, "Speak to the carer and get back to her." The records did not state what follow up action had been taken. When we spoke to the registered provider, they could not explain what action had been taken wither. There was a risk that the registered provider did not understand trends in people's experience of care. We saw one person complained about their calls

People told us they discussed their care needs with the registered provider's representative before they commenced their care package. One person told us, "They came out before the care started and checked what I wanted." One relative told us they discussed with a care-coordinator all the tasks the person needed support with and that this formed the outline for the package. Another relative told us they discussed times and days of the week when the support was needed. However we saw mixed feedback regarding people's call times. Some people we spoke with told us they received calls at times they had arranged. However, when we reviewed complaints, we saw some people received calls earlier or later than they had planned. One person complained because their call time had been changed but had not been informed care staff would arrive at a different time. Another person called to complain when care staff arrived for their 8pm call at 6:20pm. The person complained because this was too early for them to go to bed. When we spoke to their family member, they told us, "My mum sometimes declines to go to bed because its light and she doesn't want to go to bed at 7:30 – that's too early. Mum has dementia. We asked for 8:30-9:30pm."

People and their families told us they were involved in planning people's on-going care. People told us they

had review meetings where they could discuss their experience of care. People we spoke with told us they felt able to call and change their support package if their needs changed. One person told us they had changed their timings and this had been agreed. We saw in 10 care plans we reviewed that there was information about people's background so that people staff could refer to this if needed. For example, people's family members were listed, so staff knew who was involved in people's care in case they needed to be contacted.

Is the service well-led?

Our findings

At the last inspection in September 2017, we identified the need for improvements within the governance of the service and this section was rated as Requires Improvement. At this inspection, we did not see any significant improvements and saw that improvements we had previously highlighted had not been sustained and have therefore rated this section as Requires Improvement.

The registered manager had resigned from their post shortly before our inspection. 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. One of the Directors of the company we spoke with told us they were in the process of applying to become the registered manager and that they had a background in care. We identified a number of issues regarding the governance of the service, that the registered provider told us they were already working towards.

Since the last inspection we saw there had been some progress in how the registered provider was developing systems for improving people's experience of care. A Human Resources Manager was now in post to ensure recruitment and practices were safe and that the registered provider was assured staff had had the necessary checks before commencing work. Audits of staff recruitment files had been undertaken to ensure all the necessary paperwork had been completed. However other quality monitoring systems and how they operated could not be explained to us. We also saw that not all systems were fully embedded despite having been highlighted in previous inspections.

Staff training was not being monitored to ensure staff received their training in a timely way to ensure staff knowledge was up to date. There was a risk that people were being supported in a way that was not based on best practice. Whilst people we spoke with felt confident being supported by staff, we could not be certain that the risk to people was being minimised.

The registered provider reported at their last inspection that they would be monitoring staff attendance at calls in order to improve people's experience of care. At this inspection although we saw the call monitoring system had been introduced, it was not clear how this was being expanded to cover the entire service. It was not clear how calls were being monitored for the majority of people using the service.

The registered provider was not able to demonstrate a system for how they were assuring themselves of the quality of care people were receiving. Although we saw some care records had been reviewed, a system to ensure on-going monitoring was not in place. When we asked the registered provider about their sampling methods, they told us it was "Random". However, we could not determine how progress was monitored.

Accidents and incidents were not always recorded and analysed in a way that promoted people's safety. In our inspection report in July 2016, we highlighted the need to record accidents and incidents in order to review and identify learning for improvements or trends. Despite some progress during subsequent

inspections, at this inspection we saw the registered provider had not sustained an effective system for recording and reporting incidents. The provider told us there had not been any accidents or incidents since 2016 however we saw information within a person's care plan to confirm that an incident had occurred. Whilst this incident had been recorded, an analysis had not been undertaken to reduce the risk of a further occurrence. Although we reviewed 10 care plans, we could not be certain there that there were no other incidents that had not been recorded and reviewed correctly.

People we spoke with gave positive feedback on their care. Some of the people we spoke with had been with the service for some time. One person told us they had initially had some problems with their care but over time this had improved because staff had a good understanding of their care. People we spoke with told us they found the office based staff helpful and willing to respond to any concerns they had and felt assured they could get through to staff if needed. Whilst the registered provider had tried to update their practices by electronically monitoring feedback and running reports to ensure they had the information if needed. The way in which information was captured meant some trends were being missed.

The registered provider was also rated Requires Improvement overall in the last four inspections. Despite improvements at the last inspection, the registered provider did not have sustained systems in place to ensure there were regular checks of people's care to ensure they received high quality care. This was a breach of Regulation 17(2)(a) HSCA 2008 (Regulated Activities) Regulations 2014.

Staff responses to the management of the service were mixed. Some staff members we spoke with told us they were able to speak with the office based staff for help and guidance. One staff member told us they were able to speak with the directors, including the director that was applying to become the registered manager. Other staff we spoke with expressed frustration with the changes in management. The previous registered manager had been with the service for just over a year before resigning. Staff told us it was their view that this had contributed to some of the inconsistencies in how the service was being developed.

The registered provider was working with the local authority on an action plan in order to improve the quality of service provided. However, other opportunities to share and learn from stakeholders had been missed. Although the registered provider had a training provider they worked with, it was not clear what their system for arranging training was and we were unable to determine when training had been arranged for.

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	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The registered provider did not make regular checks of the service and had not ensured high quality care had been delivered despite having had improvements highlighted to them at the previous inspection in September 2017.</p>