Thames Homecare Service Ltd

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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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Thames Homecare Service Ltd is a domiciliary care agency. It provides personal care to people living in their own homes. The agency is registered to provide services for younger and older adults with a range of needs including physical disabilities and dementia.

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
People and relatives told us they were happy with their care and felt safe. However, the provider had not always assessed the risks to people's health and well-being or done all that was reasonably practicable to reduce those risks. People's medicines were not always managed in a safe way.

There were systems in place to monitor the quality of the service and recognise when improvements were required. These were not sufficiently robust to have identified the issues we found at this inspection.

People, relatives and staff were able to give feedback and felt they were listened to when they did. The provider used this to develop the service. The service worked with other agencies to help people receive joined up care.

Staff found the managers approachable and told us they felt supported. The provider completed employment checks so they only offered roles to suitable staff.

There were appropriate procedures for infection prevention and control.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 4 June 2018).

Why we inspected
The inspection was prompted in part by notification of a specific incident following which a person using the service sustained serious injury. This incident was subject to an ongoing investigation at the time of our visit. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about supporting people to remain safe from the risk of harm. 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 good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Thames Homecare Service Ltd 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 safe care and treatment and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Thames Homecare Service Ltd

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
This inspection was undertaken by one inspector on 25 and 28 September 2020.

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 supported accommodation.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.
Inspection activity started on 25 September 2020 and ended on 10 October 2020. We visited the office location on 25 and 28 September 2020.

What we did before the inspection
We reviewed the information the CQC held about the service. This included notifications of significant incidents reported to the CQC and the previous inspection report. We considered information we received regarding a specific incident of concern. Following which a person using the service sustained serious injury. We used the information the provider sent us in the provider information return. This is information

providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with the registered manager and the location's finance and administration manager.
We looked at 10 staff files in relation to recruitment and staff supervision. We viewed care plans for six people and a variety of records relating to the management of the service.

After the inspection
We requested more evidence and continued to seek clarification from the provider to validate evidence found. We reviewed policies and procedures. We spoke with two people who use the service, four relatives, four care staff and three adult social care professionals.

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 good. At this inspection this key question has now deteriorated 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.

Assessing risk, safety monitoring and management

● The provider did not always assess and manage risks to people's safety and well-being so they were supported to stay safe. This is because staff were not always given sufficiently comprehensive information about risks to people's safety and how to support them to avoid harm.

● Some people's care needs and risk assessments stated they lived with diabetes. While one person was prescribed insulin to manage this, there was no guidance or information for staff on how to recognise if the person was becoming unwell due to this condition and what they should do in that event. Training records also showed that of the four care staff who visited the people in the month prior to our visit, only one had completed diabetes awareness training over three years ago. We discussed this with the registered manager who acknowledged such information could be included in a person's care planning to support staff.

● One person was known to refuse their personal care regularly which presented a risk to their personal health and well-being. We saw the provider had worked with the person and adult social care professionals to support the person with this. However, the provider had not identified this issue or actions to take to help lessen the risk to the person in their care and risk management plans.

We found no evidence people had been harmed however, these issues indicated people were at risk of harm as known risks to their safety were not effectively managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's care and risk management plans noted if a person had any allergies staff needed to be aware of, such as to a particular medicine.

● The provider had recently introduced a new assessment tool to record people's risk and care needs more comprehensively. Risk management plans included an assessment of people's home environments to make sure it was suitable for staff to provide care safely. This included basic information about evacuation routes in case of an emergency and if a person had working smoke alarms fitted.

Using medicines safely

● Some people's medicines support records were not always accurately maintained.

● Staff signed people's medicines administration records (MARs) to indicate they had supported people to take their prescribed medicines. We saw staff had completed MARs in July and August 2020 that indicated they routinely supported a person to take 'when required' medicines. A 'when required' medicine is one taken only when needed, such as for pain relief. There were instructions on the daily limit of tablets the person could take for one of these medicines. However, the registered manager clarified this was actually a regularly prescribed medicine for the person and the wrong form with incorrect instructions had been used.

The MAR also did not state the prescribed dose of this medicine. This meant the prescriber's directions were not set out clearly and indicated some people were at risk of not always receiving their medicines as prescribed.
● Additionally, the provider had audited these MARs at the end of each month and had not identified and addressed the issues we found. This indicated that processes to make sure people received their prescribed medicines safely were not always effective. Similarly, while we checked that daily care records noted staff had supported another person with their pain-relieving medicine one evening, the audit of their MARs had not identified and addressed that there wasn't a staff signature to indicate the support had taken place. We brought these issues to the attention of the registered manager so they could address the matters promptly.

We found no evidence that people had been harmed however, these issues indicated medicines support was not always managed in a safe way. This was a further breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We viewed other people's MARs and saw these had been completed appropriately to indicate staff had supported people with their medicines as prescribed. We saw the provider had audited these MARs to ensure staff completed them correctly and acted to address issues these audits identified.
● Staff had received training on providing medicines support. Senior staff conducted periodic spot-checks and annual assessments of care staff's medicines support competency to check they were supporting people with their medicines safely.

Learning lessons when things go wrong
● There were procedures in place for responding to incidents and accidents. We saw the care coordinators recorded incidents and actions taken in response to them on an ongoing basis. Managers stated they checked these logs daily to ensure issues were responded to. We saw the managers also recorded complaints and quality concerns and the lessons learnt from these. However, it was not always clear how the lessons learned from these events for improving the service were identified and communicated to staff. The finance and administration manager informed us they discussed incidents and learning from them with staff at team meetings. However, there was no indication of this taking place in the records of the 12 meetings held with office and care staff in the six month prior to our visit.
● There was no systematic analysis of incidents to see if any safety-related trends or themes could be identified to inform service improvements. We discussed this with the registered manager who said they planned to conduct an analysis after our visit and document the findings and actions taken.
● People who used the service and relatives told us the provider responded to incidents, concerns or issues they raised. One relative told us that "I felt they responded well [to an incident]" and "They kept us updated about what they were doing."

Systems and processes to safeguard people from the risk of abuse
● The provider had policies in place to protect people from the risk of abuse.
● Care workers could describe how they would recognise and respond to safeguarding concerns.
They told us senior staff and the registered manager listened to them when they raised concerns and responded to these promptly. Training records showed all staff had completed safeguarding adults training. Some staff were overdue the annual repeat of this training which the provider required, although some training arrangements earlier in the year had been disrupted due the COVID-19 pandemic. The provider had recently re-started training sessions with care staff to address this. Records showed staff also completed whistle-blowing awareness training.
● At the time of the inspection we received information suggesting some people were not always safe and protected from avoidable harm or abuse. These concerns were being investigated when this report was

being written.
● When safeguarding concerns had been raised since our last inspection, the provider had engaged with local authorities to look into the concerns and ensure people were safe.
● Both people and relatives told us they felt safe with the care staff who visited them. Their comments included, "Yes, of course I feel safe. They know what they are doing" and "We feel very safe with the carer, she is excellent."

Staffing and recruitment
● The provider deployed enough staff to support people to stay safe.
● People were supported by staff they had got to know and felt comfortable with. People and relatives told us the same care workers visited people regularly. Staffing rotas also indicated this.
● People and relatives said care staff visited them at the times they wanted and staff usually arrived on time. They told us their care workers or the provider called to let them know if staff were running late, for example due to traffic problems or if there was an unforeseen issue with another customer. Care workers told us they had sufficient time to travel between visits and enough time to provide care to people without having to rush.
● The provider used electronic call monitoring systems to check care staff were visiting people at the right time. Care coordinators and managers reviewed these systems throughout the day.
● Staff recruitment records we saw showed the provider completed necessary pre-employment checks so they only offered roles to fit and proper applicants. These included gathering previous employment references and obtaining criminal records checks with the Disclosure and Barring Service.

Preventing and controlling infection
● There were appropriate arrangements for preventing and controlling infection.
● The registered manager provided staff with suitable personal protective equipment to keep themselves and people safe. This included face masks, gloves, aprons, goggles, shoe protectors and hand sanitiser. Care staff said they could always access supplies of this which the agency would deliver to them when needed. People and relatives said staff always wore this equipment when they visited.
● The provider gave staff information about COVID-19 and they completed awareness training on this and how to use the protective equipment safely. Managers reinforced safe working practices with staff at regular online team meetings. Relatives told us staff visited people before the COVID-19 lockdown to explain the equipment staff would be wearing to be able to work safely. A relative commented, "They said they wanted to act now to be safe; I was very happy with that."

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 good. At this inspection this key question has now deteriorated 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; Continuous learning and improving care; 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

- The provider carried out a range of checks and audits to monitor safety and quality and make improvements when needed. However, this system of checks had not been consistently effective as it had not identified and addressed the issues we found during our inspection.
- The quality assurance systems had not identified some risks to people's health and well-being or ensured the provider acted to mitigate those risks. The monitoring processes had not identified and addressed issues regarding maintaining accurate records to ensure people received their medicines safely as prescribed.
- Staff used daily reporting systems at the office to log concerns or queries regarding people's care and actions taken in response to these. The registered manager said these enabled the provider to monitor the service and address issues promptly. However, in one case we saw that the provider only recorded on these systems the concern that staff had not signed to indicate supporting a person with their pain relief medicine until after we discussed this with the registered manager.
- One person's care and risk management plans stated that their relative had legal authority to make decisions about the person's care and welfare on their behalf. However, the provider did not have evidence of this authority and regular auditing and review of the person's plans had not identified this. We brought this to the attention of the finance and administration manager so they could address the matters promptly.
- The provider had some systems in place to support continuous learning and improvements to the service. However, as the recording of this learning and the systematic analysis of incidents required improvement, this and the other issues we found indicated that these systems were not always effective.

These issues indicated systems were either not in place or robust enough to demonstrate safety and quality was effectively managed, that there was continuous learning and complete, up to date records of care were maintained. This placed people at risk of harm. This demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Supervisors conducted regular spot-checks of care staff when they were visiting people to monitor staff performance. The registered manager told us they did not inform staff when these were taking place. People we spoke with and care staff confirmed this and that they appreciated these checks taking place. Care staff

stated, "You don't know who is coming, you have to be sure you are doing a good job" and "I like that they are coming in and looking at what we are doing." Records of these checks showed people were asked to give feedback about their care.
● Adult social care professionals told us the provider was responsive to requests for information and engaged in investigations and enquiries when concerns were reported to them. People's relatives told us the provider responded to and addressed issues when they raised.
● We saw the provider had introduced new formats to improve the use of people's medicines administration records and risk and care needs assessments in response to previous inspections.
● We saw evidence the provider was preparing to implement a new online care planning and monitoring system in the weeks following our visit. The registered manager and finance and administration manager reported this was a development initiative to improve how the provider monitored the care provided, staff performance, care visits, and medicines support. The registered manager stated the new system would help them address improvement issues required.
● The provider displayed the previous inspection ratings at the branch office and on their website.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People and relatives said they were happy with their care. One person said, "If someone else said about using them [then] I would say they are a good company."
● The registered manager spoke passionately about the values of the organisation and their commitment to supporting the staff teams to provide a good service that met people's needs. For example, they reported that they awarded staff vouchers and other incentives when they received compliments for the care they provided. Staff also spoke about being committed to providing sensitive care to people.
● Care staff told us they felt supported by their managers and the office staff. Their comments included, "I feel supported", "You feel like someone is behind you supporting you", and "I am very comfortable with them, they always listen to us."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and relatives told us the provider regularly asked them for feedback about the service. One relative said, "Yes, they ask me all the time."
● The provider had conducted satisfaction surveys with both the people who use the service and staff in the year before our inspection. Reports of these surveys indicated the majority of respondents were satisfied with their care service or felt supported and valued by their employer.
● The provider held regular meetings with both care staff and office staff, including care coordinators and supervisors. Records of these meetings indicated they were used to discuss issues such as safe working during the pandemic, use of PPE and ensuring supplies of this to care staff, and other service developments. Care staff told us the provider had sometimes held these meetings in the evening so staff could attend. The provider held online meetings with care staff during the COVID-19 pandemic so these could still take place in a safe manner.

Working in partnership with others
● The service worked in partnership with other agencies, such as social workers, GPs and other healthcare professionals, to help to provide coordinated care to people. For example, informing a local commissioning authority of changes in people's care needs. This helped people to experience joined-up care from the agencies who supported them.
● The provider had worked in partnership with adult social care professionals to address people's concerns and respond to people's requests to change their care arrangements.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not always ensure care and treatment was provided in a safe way for service users. Regulation 12(1)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not always effectively operate systems and processes to assess, monitor and improve the quality of the service and to assess, monitor and mitigate risk. Regulation 17(1)