Touch of Care Limited

Touch of Care Limited

Inspection report

5 New Broadway
Worthing
West Sussex
BN11 4HP

Tel: 01903890943

Date of inspection visit:
27 February 2019

Date of publication:
28 May 2019

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:
Touch of Care Limited is a domiciliary care service providing support and personal care to people living in their own homes. It is registered to provide personal care to older people and people who are living with dementia and/or other long-term conditions. At the time of our inspection, one person was using the service.

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

People's experience of using this service:
● We met and spoke with one person using the service and their relative. They had no concerns about the staff who provided the care and support. The relative commented, "I think they're very good". The registered manager told us, "The girls always take to [named person] and she responds well to them. There are two carers at a time to get her in and out of bed, so I don't think much can go wrong".
● Despite this, risks to the person had not been identified, assessed or fully documented. There was insufficient guidance to staff on how to support the person safely in relation to their care needs. There was a lack of information about potential risks relating to falls, medicines management and skin integrity. This put the person at risk of unsafe care and treatment.
● Recruitment systems were not robust to ensure new staff were recruited safely. There were inaccuracies within the paperwork relating to potential new staff. People were put at possible risk because new staff were not vetted properly. Where new staff had a criminal record or criminal convictions, the registered manager had failed to risk assess them to ensure they were suitable to care for people in their own homes.
● Systems had not been established to measure and monitor the service overall or the quality of care delivered. However, surveys had been sent out and one person had responded positively.
● Lessons were not learned when things went wrong. The registered manager had not taken sufficient steps to ensure the safety of people receiving a service. The registered manager did not have a good understanding of how to meet the regulatory requirements.

The service continued to meet the characteristics of Inadequate in the areas inspected. More information is in the full report.
Rating at last inspection: The last inspection report was published on 22 February 2019. The overall rating was Inadequate.

Why we inspected:
This was an unannounced, focused inspection which took place following concerns raised by the local authority.

Enforcement:
The inspection checked to see whether the provider/registered manager was meeting the condition

imposed in a Notice of Decision issued by CQC on 11 January 2019 and that this Notice of Decision remained appropriate. We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals is added to reports after any representations and appeals have been concluded.
For less serious concerns, you can see what action we told the provider to take at the back of the full version of this report.

Follow up:
We will continue to monitor and review the service in line with our methodology for 'Inadequate' services.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our Safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Touch of 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by concerns raised by the local authority in relation to a safeguarding incident. This incident is subject to a separate investigation by the local authority and, as a result, this inspection did not examine the circumstances of the concern. At the last inspection, which identified three breaches of regulation, we served a Notice of Decision to the provider. This Notice imposed a condition that the provider should not take on any care packages under the regulated activity without seeking prior written consent of CQC. At this inspection, we wanted to check that the provider was meeting the restrictions placed on their registration and that the Notice remained appropriate.

Inspection team:
The inspection was undertaken by two inspectors.

Service and service type:
Touch of Care is a domiciliary care service providing support and personal care to people living in their own homes who are in receipt of the regulated activity of personal care. The service supported older people and people living with dementia, mobility issues and other long-term medical conditions, to enable them to continue living in their own homes.

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 was an unannounced, focused inspection.
We visited the office location on 27 February 2019 to see the registered manager and to review care records and other records relating to the management of the service.

What we did:
Before the inspection we reviewed the information we held about the service. This included information that had been shared with us from the local authority and other agencies about events that had occurred at the service. This information was used to decide which areas to focus on during our inspection. On this occasion, the provider was not asked to complete a Provider Information Return. Providers are required to send us key information once annually about the service, what they do well and improvements they plan to make. This information helps support our inspections.

During the inspection:
- We visited and spoke with one person and their relative who were supported by staff in their own home;
- We spoke with the registered manager and the deputy manager;
- We reviewed one person's care records, three staff recruitment files and results of a survey completed by people who used the service.

Inadequate

Is the service safe?

Our findings

We have inspected this key question to follow up the concerns found during our previous inspection on 10 January 2019 when we rated this key question as Inadequate. The concerns related to staff recruitment practices, risk assessments for people, medicines management, daily care records and the deployment of staff. This key question continues to be rated as Inadequate.

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse; Using medicines safely

- At the last inspection we found that risks to people were not assessed or recorded. No records were available to show that risks to people were assessed.
- At this inspection, risks to the person who was using the service had not been identified or assessed as needed. This person's care record identified that they were 'prone to falls' and that they required a walking aid to mobilise. No consideration had been given in relation to what actions were needed to keep the person safe.
- This person was on a particular medicine that meant there could be serious consequences if they sustained a fall. This had not been identified within the person's care record or the related risk assessed. There was no guidance for staff on what they should do if the person sustained a fall.
- We discussed this issue with the registered manager who was not aware this person was prescribed blood thinning medicine. The registered manager was also not aware of national best practice guidance in relation to this, for example, from the National Institute for Clinical Excellence (NICE) and people who received a head injury following a fall.
- The person was prescribed emollient creams which staff administered. Emollients are used to keep skin moist and flexible and to prevent cracks. No assessment had been completed in relation to the person's skin integrity and their risk of developing pressure areas.
- The care record for this person included that they required assistance with cleanliness and that staff would give them a wash. However, it was not clear whether the wash was in the form of a bath or shower as the care plan simply stated they needed, 'all personal care carried out'. This put the person at risk since the information was not sufficient to provide detailed guidance for staff on what they were required to do or how this should be done safely.
- The person's needs were not fully assessed which placed them at risk of harm. The registered manager asked us several times how they should complete risk assessments.
- There were no systems or processes in place to show how people were protected from the risk of abuse. There were no records to show how any accidents or incidents were recorded or reported. The registered manager told us that staff completed on line training in a range of areas, including safeguarding, but there were no records to corroborate this.
- One person received three care calls from staff every day. Two of these calls were of 15 minutes' duration.

We asked the registered manager how they were able to complete the personal care tasks identified within this timeframe. The registered manager told us that staff would 'double-up' for these calls and that, if necessary, the person could be dressed and have their topical cream applied while they were sitting on the commode as this would save time. This is unacceptable and undignified for the person receiving care.

● Best practice guidelines from NICE state that, 'Home care visits to elderly people should last for at least half an hour and be centred around personalised care rather than a one-size fits all service'. A relative commented that care visits often felt like staff were, "in a rush".

● According to the care plan, one person's medicines were managed by their relative. However, in the completed daily records, it showed that staff applied cream to the person's skin, but this had not been assessed. For example, there was no guidance for staff on how the cream should be applied, how often or to which part of the person's body. The registered manager had not understood that prescribed creams are also medicines and should be managed appropriately.

The provider had failed to assess, record and mitigate risks to people's health and safety. Medicines were not safely managed. This is a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● At the last inspection, we identified that recruitment practices did not always ensure the suitability of staff. Risks to people were not always assessed when recruitment decisions were made. There were no risk assessments in relation to potential new staff who had a criminal record or convictions that had been identified on their Disclosure and Barring Service (DBS) checks.

● At this inspection, the registered manager showed us documents relating to two potential new members of staff. The documents included application forms, references and DBS checks.

● It is the provider's responsibility to ensure that new staff are fit to work in a care setting. We looked at the recruitment records for two new staff. The application forms showed gaps in their employment histories and references obtained did not always match with the information recorded in the application forms.

● For example, in one staff file the application form showed the potential new staff member had worked with three organisations, including with Touch of Care between 2014/21015. The references on file did not relate to any past employment and there was a gap in the employment history between 2007 and 2014. The registered manager informed us this person was not working during this time period. However, when we checked one of the references, this stated the person had been employed at one company between 2002 and 2017.

● The information in relation to this reference had been recorded by the registered manager who told us they had made contact with an insurance company, at which this potential new staff member had worked. Apart from the name of the insurance company, there was no further information, such as who was providing the verbal reference or the address of the insurance company. If this potential staff member had been employed during the time periods noted, it would have meant they commenced employment before they reached school-leaving age.

● Staff records were inaccurate and lacked information to ensure that new staff were appropriately vetted and suitable to work in a care setting.

Learning lessons when things go wrong

● At the last inspection, we found areas of concern in relation to risk management and staff recruitment. We reported on these in our report which was published on 27 February 2019.

● Lessons had not been learned and insufficient actions had not been taken by the registered manager since the last inspection to meet the concerns that were raised.

The provider had failed to ensure that safe recruitment practices were followed. This is a continuing breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- People were protected from the risk of infection.
- The registered manager told us that when delivering personal care, staff wore protective equipment, such as disposable aprons and gloves.

Inadequate

Is the service well-led?

Our findings

We have inspected this key question to follow up the concerns found during our previous inspection on 10 January 2019 when we rated this key question as Inadequate. The concerns related to the lack of formal quality assurance processes and records relating to people's care. We found these areas had not improved and the rating for this key question continues to be Inadequate.

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; Continuous learning and improving care

- At the last inspection, due to personal circumstances, the registered manager was not available and so was not involved in the inspection process.
- We spent time with the registered manager at this inspection who told us of the actions they had taken to date in relation to concerns raised at the last inspection. We discussed the need for detailed assessments before people started to use the service, care planning and risk assessments.
- There was very little information on file about the person whose care plan we reviewed at this inspection. Information in relation to the person's medical history, their personal life, likes and dislikes was lacking. There was no record of how the person's needs were assessed before they came to use the service. When we asked the registered manager if we could look at this person's care records, they said, "You won't be able to see their records. These are filled in and are on the computer". Later, the registered manager said, "The person we're currently looking after - all her records will be in her home. We don't have records in the office".
- We were later provided with a copy of this person's care plan and daily records were completed which were kept at the person's home. The information provided was not sufficient to ensure the person's needs had been fully assessed and the guidance provided to staff about the person's care and support needs was poor.
- Issues we had highlighted as a cause for concern at the last inspection were still significant. Steps had not been taken by the registered manager to rectify these concerns.
- Staff were not recruited safely. Systems had not been developed to ensure all the necessary checks were made to ensure potential new staff were safe to care for people in their own homes.
- There was no evidence to show that continuous learning took place to improve the care that people received.

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

- The registered manager did not demonstrate a good understanding of their responsibilities in relation to delivering a service that met regulatory requirements.

● There were no quality assurance systems and a lack of oversight in relation to the monitoring of complaints, accidents and incidents.
● Paperwork in relation to people's care needs and the recruitment of staff was incomplete. We asked the registered manager about record-keeping and they said, "I don't know where all the paperwork has gone".
● Apart from some questionnaires sent out to people, there were no systems or records to measure and monitor the service provided.

The provider had failed to establish systems or processes to assess and monitor the quality and safety of the service provided. This is a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● At the last inspection, the registered manager had not effectively sought feedback from people, their relatives and professionals to improve the service provided.
● Since the last inspection, the registered manager had sent out questionnaires to people who had used the service.
● The feedback we looked at was from one person who was currently receiving a service and this was positive.

Working in partnership with others
● The registered manager had worked with others in an attempt to deliver an effective service.
● As a result of the Notice of Decision which imposed a condition on the provider's registration, the registered manager was required to obtain written consent from CQC before providing personal care to people. The registered manager had done this and shared information with CQC which showed how they planned to deliver care to people in their homes and to show how they recruited new staff.
● The registered manager had met with representatives of the local authority to discuss their plans for providing and managing the service.

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 There was a failure to assess, record and mitigate risks to people's health and safety and a lack of oversight relating to the management of medicines. Regulation 12 (1) (2)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems did not assess or mitigate risks relating to the health, safety and welfare of people who may be at risk from the carrying on of the regulated activity. Regulation 17 (1) (2)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe recruitment practices were not implemented or followed. Regulation 19 (1) (2) (3)