Total Community Care Limited

Total Community Care

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
Total Community Care is a domiciliary care agency providing support to people living with spinal injuries and neurological conditions in their own homes.

At the time of inspection, the service was providing support to 75 people ranging in age from 20 to 80 across the country.

People's experience of using this service and what we found
Medicines were not always administered safely. We found some people were being administered medicines without necessary documentation being in place. This placed them at risk of potential harm as staff did not have the appropriate guidance about how to administer medicines.

Daily records were not always completed which placed people at risk of not having their needs met consistently.

Staff were passionate about providing person centred care and provided support in a way that empowered people.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

The service was not always well-led. Whilst staff felt supported by their colleagues and management, systems were not robust at identifying areas that needed improvement or to drive consistency with how care was provided.

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 good (published July 2019).

Why we inspected
We received concerns in relation to how some people's complex care needs were being met. 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 improvement. 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 Total Community Care 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 monitor the service 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 how people received their medicines, and how daily records were kept. We also found breaches in how the service was led and governed at this inspection.

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

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? People were not always safe.	**Requires Improvement**
Is the service well-led? The service was not always well-led	**Requires Improvement**

Total Community Care

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 and a Specialist Advisor. A Specialist Advisor has particular knowledge in relation to the area the service provides care to. The Specialist Advisor case tracked people using the service and reviewed relevant documents and records held b by the person.

An Expert by Experience made telephone calls to people who used the service and spoke to some people's relatives.
An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Two inspectors carried out telephone calls to staff working at the service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service 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
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before the inspection

We reviewed information we had received about the service since the last inspection.

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

During the inspection-
We spoke with the registered manager to understand the structure of the service and how it was organised. We also looked at a number of policies and documents kept by the service.
We reviewed a range of records. This included 12 people's care records and 12 people's medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection –
We continued to seek clarification from the provider to validate evidence found. We met with the nominated individual to seek assurances and seek clarification regarding the running of the service. We looked at training data and quality assurance records, policies and procedures.

We spoke with six people who used the service and two relatives about their experience of the care provided. We spoke with 18 members of staff including the nominated individual, registered manager, commercial director, operations manager, care managers, clinical nurses, care workers and trainers.

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.

Using medicines safely

● People did not always receive medicines safely. Records showed and staff told us, some people's medicines were given without Medication Administration Records (MARS) being in place. This meant staff did not have adequate guidance about people's medicines, which put people at risk of receiving the wrong medicine or dosage.

● We found for people that had MARs in place, these were not always completed accurately. For example, one person's MARs had not been completed for three full days and nights. This meant we could not be assured people had received medicines as prescribed which may have impacted their health.

● As required medicines were not always administered safely. Some people were prescribed medicines that did not need to be administered all the time. Protocols telling staff how to administer these medicines were not always in place. This meant there was a risk people would not receive their as required medicines when they needed them or as prescribed. We found one person was prescribed medicines that needed to be given four to six hours apart. Records showed they had been given their medicines earlier than the prescribed recommendation. This meant there was a risk of harm to the person from receiving medicines too close together.

Assessing risk, safety monitoring and management

● Risks to people were not always comprehensively assessed and reviewed. For example, one person chose to have a medical procedure which was not in line with best practice. A risk assessment had not been completed which meant staff did not have guidance about what to do should there be any concerns.

● Antecedent, Behaviour and Consequence (ABC) Charts were completed for people with distressed behaviours. Whilst staff told us information recorded was discussed during handovers; it was not always clear how they were reviewed to inform people's risk assessments and care plans. This meant opportunities to promptly identify and respond to changes in people's behaviour could have been missed.

● Daily records were not always completed. Two people had chosen not to have care records completed about them. This meant there were no accurate records to identify if people's health needs were changing, or that staff had followed appropriate steps to ensure people were safe and cared for. Opportunities to review people's needs for themes or trends to improve the quality of care they received were missed.

● Equipment required to care for people were monitored. Staff were responsible for ensuring equipment was working and people had back up equipment and contact details of manufacturers available to them.

Medicines were not always administered as per the service's policies and procedures and did not always

follow best practice guidance. This may have placed people at risk of harm. The service did not maintain records evidencing how care and support was provided. While we found no evidence people had come to harm, these issues were breaches of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● Staff were able to identify safeguarding concerns and told us they would report any concerns to care managers. Staff were however unable to tell us how any concerns were followed up. This meant steps taken to reduce risk may not have always been taken.

● A whistle blowing policy was in place but not robust as there was not enough information about how and where to report concerns to. Staff told us however they felt able to share concerns with management if required.

● People felt safe and in control of their care. One person told us "I feel extremely safe and well looked after." Staff told us they knew the people they supported well and responded to be people's care needs as required.

● People were protected from discrimination. Staff support people to lead their lives in meaningful ways and provide non-discriminative and non-judgmental care. For example, people were supported to express their sexuality and dress in ways that make them feel comfortable. A relative told us staff "treat [person] as a normal human being and see beyond their level of disability."

Staffing and recruitment

● Training programmes tailored to people's needs were offered. We reviewed staff training records however and found some new staff had not completed all relevant training prior to supporting people. One staff member told us "I have not been properly trained with the machines and stuff." Staff did not undertake tasks they had not been trained in, but lack of training in areas required prevented them from supporting people wholly.

● Staff were safely recruited. We viewed three staff recruitment files which evidenced safe recruitment practices had been followed.

● People were supported by consistent teams of staff. People were actively involved in advertising for and recruiting staff who would be supporting them. One person told us, "I have handpicked my carers and they all suit me and my needs."

● Staff completed shadow shifts prior to working with people. This enabled staff and people to get to know each other and for staff to feel confident and competent before supporting people on their own. One staff member told us "I found the training really good, we had three shadowing shifts."

Preventing and controlling infection

● Policies and procedures were in place to manage COVID-19. Staff told us they were wearing Personal Protective Equipment (PPE) in accordance with government guidance and took part in weekly Polymerase Chain Reaction (PCR) testing.

● The service had adequate stocks of PPE. Care managers collected PPE, or it was distributed to people's homes on a weekly basis or via courier as required.

● The service were able to fit face masks for staff supporting people with Aerosol Generating Procedures (AGPs). AGPs are medical procedures that can transmit airborne particles into the environment. The use of additional PPE is necessary to reduce the risk of transmitting and contracting COVID-19.

● The service ensured staff and people were protected from the risk of COVID-19. Some people told us, and we observed documents which indicated people did not want staff to wear PPE in their homes. Care managers had difficult conversations with people to ensure the government guidance on PPE use was followed to reduce the risks associated with COVID-19.

Learning lessons when things go wrong

● Staff recorded and reported incidents. The registered manager told us these were discussed at monthly meetings and learning was shared with staff to minimise the likelihood incidents would happen again.

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

- Systems and processes were in place but were not robust at identifying concerns. For example, quality assurance systems and processes including, but not limited to, medicine administration did not identify that not all people were safely receiving medicines or that improvements were required. This meant opportunities to improve people's care were missed.
- The service did not consistently implement its own policies. To meet people's preferences the service failed to follow their own procedures. This may have led to people being placed at harm. For example, one person had supplementary documents in place which were not consistently completed. This meant staff were confused about the care the person had received and it appeared staff were failing to ensure people's care needs were being met.
- The use of technology was limited which impacted upon how information was audited and shared. Not all staff had access to all systems so care records were stored locally. This meant the registered manager could not have nor maintain comprehensive oversight of the delivery of care at all times.
- There was a culture based upon assumptions within the service. Complacency had developed as some people were supported by consistent staff for a number of years. Staff told us they shared concerns with care managers, but they were not always assured the required actions were taken at the right time. For example, a staff member told us they raised concerns about poor practice with management, but "things never get done." Opportunities were missed to ensure practice was effective and following safe guidelines at all times.

The registered manager was not able to maintain oversight of the delivery of care at the service and did not consistently identify areas of concern independently. This impacted upon the ability of the service to deliver and improve the quality of care people received.
While there was, no evidence people had come to harm, these were breaches of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff received regular supervisions. Staff told us they were able to seek support from care managers and clinical nurses as required. Additional training opportunities were provided if people's needs changed.
- Team meetings were held regularly. Staff successes and people's stories were shared to enable others to learn and support people to lead more fulfilled lives.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The registered manager and staff were passionate about providing person centred care. This was sometimes delivered at the detriment of the service however as policies and procedures were not consistently followed by the registered manager.

● Staff mostly felt supported. Staff told us the working environment was positive and senior managers could be contacted at any point for advice and support. Some staff however had different experiences of supervision and support from management due to the complexity of the people they were working with.

● People felt able to direct their care. People told us staff supported them in ways that made them happy and promoted their wellbeing.

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 registered manager was open and acknowledged there were certain situations and some complaints that had not been dealt with effectively. They were aware of their legal responsibilities when something went wrong, and were keen to ensure people received a transparent service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

●The service was actively involved in with spinal injury specialist organisations. The service took part in conferences and invited people to share their experiences at these events.

● People's views were sought about their care. Quality assurance questionnaires were sent to staff and people alike to gather their perspectives. People told us staff listened to them and addressed concerns where possible.

Working in partnership with others

● Staff worked in partnership with local health and social care professionals. Staff shared information and communicated effectively with health and social care professionals and relevant agencies. This meant people's needs were met by a multi-disciplinary team.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always administered safely. Some people did not have MARs in place but staff administered medicines. People were at risk of harm due to poor medicine management and practice. People did not always have daily care records in place. Some people used variants of Total Community Care documents which were not consistently completed or were misleading. This placed people at risk of not having their care needs met, and of not receiving appropriate care if their health deteriorated.

The enforcement action we took:

Warning Notice served.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Lack of oversight of the service. Processes and systems not robust to identify areas of poor and unsafe practice. Opportunities to improve the quality of care people received missed.

The enforcement action we took:

Warning Notice served.