T.N.P. Homecare (Uk) Limited

TNP Homecare (UK) Limited

Inspection report

TNP House
15 Comberford Road
Tamworth
Staffordshire
B79 8PB

Tel: 01827316177

Date of inspection visit:
23 July 2019
24 July 2019

Date of publication:
15 October 2019

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
TNP House is a residential care home providing personal care to 12 older people, some of whom were living with dementia, had a physical disability or sensory impairment.

The home is divided over three floors, bedrooms were located on the ground and first floor. Two lounges and a dining room were situated on the ground floor. Bathrooms/shower rooms were situated on each floor. An office was located on the second floor. A passenger lift was in place to enable people to access all floors. People had access to a paved garden, one area of the garden was accessible to people who required the use of a wheelchair.

People's experience of using this service and what we found
The providers governance was ineffective to review, assess and monitor the quality of service provided to people. The provider worked with other agencies. However, concerns relating to people's safety had not been shared with the local authority safeguarding team. The provider had not displayed their CQC rating on their website. The provider did not notify CQC of significant events that had occurred in the home which, they are obliged to do by law.

Identified risk to people were not always managed effectively to protect them from further harm. People were not always safeguarded from the risk of potential abuse. The management of medicines needed to be improved to reduce the risk of people receiving contaminated medicines. Systems in place to monitor hygiene standards within the home needed to be reviewed to ensure people were not placed at risk of avoidable infections. Monitoring systems were not effective to ensure lessons were learned when things went wrong.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests. Deprivation of Liberty Safeguards were not always reviewed to ensure they were still required. People had a choice of meals, but they were not always supported with their meal in a dignified manner. Staff had access to training. However, shortfalls identified at our inspection showed that skills learned were not always put into practice. The environment was not 'dementia friendly' and this could add to people's confusion.

Staff were kind and had a gentle approach. However, the lack of understanding of safeguarding people from the risk of abuse compromised the care provided to people. There was no evidence of people's involvement in making decisions about their care and treatment to ensure their preferences were met. People's right to privacy and dignity was not always respected by staff. At the time of our inspection no one was receiving end of life care.

The assessment of people's needs did not identify people's involvement to ensure they received care and treatment the way they liked. People were not encouraged by staff to engage in meaningful activities to

promote their mental wellbeing. Complaints were not always listened to or acted on.

People and staff were aware of who was running the home. The culture of the home presented as warm and friendly. The registered manager and staff were confident there were sufficient staffing levels to meet people's needs. Although at key times people did not get prompt support. People had access to relevant healthcare services to promote their physical and mental health needs.

Rating at last inspection
The last rating for this service was good (published 4 March 2017).

Why we inspected
This was a planned inspection based on the previous rating

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our reinspection programme. If we receive any concerning information we may inspect sooner

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

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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

TNP Homecare (UK) Limited

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by one inspector.

Service and service type
TNP House is a 'care home.' People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. The registered manager was also the registered provider. This means they 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 23 July 2019 and ended on 24 July 2019.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.

During the inspection
During the inspection we spoke with two people who used the service, three care staff and the registered manager. We looked at two care plans, risk assessments, staff training records, the fire risk assessment,

quality monitoring audits and medication administration records.

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.

Systems and processes to safeguard people from the risk of abuse
•One person had made an allegation of abuse. However, the registered manager told us this allegation had not been shared with the local authority safeguarding team. This meant the person remained at risk of potential harm.
•The action of a person's relative placed them at risk of potential harm. However, the registered manager had not shared their concerns with the local authority to safeguard the person and they continued to be at risk of harm.
•Although all the staff members we spoke with demonstrated a good understanding of how to safeguard people from the risk of abuse, action had not always been taken to protect people living in the home.

This is a breach of Regulation 13, Safeguarding service users from abuse, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection visit the provider told us they had shared concerns about the alleged abuse with the local authority safeguarding team to protect people from the risk of further harm.

Assessing risk, safety monitoring and management
•Potential risks to people were not managed effectively to ensure their safety.
•One person was at risk of swallowing objects. The registered manager was unable to demonstrate what action had been taken to reduce the risk of harm to them. The registered manager told us a risk assessment had not been put in place.
•The same person had a health condition that needed to be monitored regularly. However, discussions with staff identified they were unsure when medical advice and support was required.
•A risk assessment showed the same person was at high risk of falls but control measures were not identified to reduce the risk of further falls.
•Fire drills were carried out. However, records did not show that all staff were involved in fire drills. The registered manager told us that only one night staff member had been involved in a fire drill since 2019.

Using medicines safely
•A risk assessment or monitoring system was not in place for one person who managed their medicines. This meant the registered manager was unable to demonstrate the person was taking their medicine as prescribed.
•Containers where medicines were dispensed were unclean and placed people at risk of receiving contaminated medicines.

•Written protocols were not in place for the safe use of 'when required' medicines.

Preventing and controlling infection
•There was no infection, prevention and control (IPC) lead in place to monitor hygiene standards in the home.
•Cleaning audits were carried out. However, these audits did not identify brown matter on one bed.
•We observed that frames on raised toilet seats were rusty and would compromise the cleaning of this equipment.
•Staff told us three people required the use of a hoist. Two people shared the same sling which placed them at risk of cross infection.

Learning lessons when things go wrong
•We found where things had gone wrong the registered manager had not always taken immediate action to reduce the risk to people.
•Action had not been taken to safeguard people from further risk of abuse.

This is a breach of Regulation 12, Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection visit the provider told us they had taken action to mitigate the risk to people.

Staffing and recruitment
•Staff told us there were sufficient staffing levels to meet people's needs. However, we observed that staff were not always present at mealtimes to support people with their meals.
•The registered manager told us two staff members where provided on each shift. There were three areas in the home where people ate their meals. This meant people were at risk of not receiving sufficient support at mealtimes.
•The registered manager told us that three to four people required support with their mobility. Two staff members were provided during the night time. The registered manager was confident staffing levels were sufficient to evacuate in an emergency.
•One person who use the service told us, "When I buzz (nurse call alarm) the staff come quickly, sometimes I think they are just outside the door because they are here so quick."
•Staff were recruited safely to ensure their suitability to work in the home.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

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 effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

•The registered manager told us five authorised DoLS where in place and the staff we spoke with were aware of this.
•We observed a DoLS authorisation allowing staff to administer a person's medicines covertly (medication hidden in food) expired five months ago. Discussions with the registered manager confirmed this had not been reviewed or an extension applied for. The provider's medication policy stated, "Regular reviews to determine if covert administration is still needed." This meant the registered manager was not complying with the law or their own medication policy.

This is a breach of Regulation 11, Need for consent, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•Staff told us they had received MCA and DoLS training and demonstrated a good understanding.

Supporting people to eat and drink enough to maintain a balanced diet
•We observed that people were not adequately supported with their meals.
•We saw four people in the lounge with their meal on their lap. One person's plate was slipping off their lap

and their food had fallen onto their chest.
•We observed two people eating with their fingers and staff were not present to encourage them to eat with their knife and fork to ensure their dignity.
•When we shared these concerns with a staff member they said, "I only popped out for a few minutes."
•One person required a special diet for their known health condition. However, the person's relatives had given them foods that were not part of their diet, which had a negative impact on their health.
•Where concerns had been identified about the amount people drank, charts were in place to monitor this. However, these charts did not tell staff how much people should drink over a 24-hour period, nor calculate the total amount. Staff did not have access to information to tell them what to do if a person did not drink enough.
•Two people we spoke with told us the food was good. One person told us they had a choice of meals and could have a drink at any time.

Adapting service, design, decoration to meet people's needs
•The home was unsuitable for people living with dementia.
•Although signs and pictures were on toilet doors to help people living with dementia find their way around. There was no signage on bedroom doors.
We observed one person living with dementia walking around the home and told a member of staff they were lost. Dementia can impact on a person's vision and winding corridors and lots of doors without signage could add to their confusion.
•A cupboard where the boiler was located was found to be unlocked. People living with dementia could enter this cupboard and have trouble finding their way out.
•Grab rails were situated around the home to assist people with reduced mobility.
•Assisted baths, showers and raised toilet seats were in place to help people with limited mobility.
•A passenger lift enabled people access all areas within the home.

Staff working with other agencies to provide consistent, effective, timely care
•The registered manager worked with other healthcare professionals to ensure people's physical and mental health needs were met.
•Discussions with the registered manager and the care records we looked at showed people had access to a community psychiatric nurse to promote their mental health.
•One person told us when they are unwell the staff called the GP out to do a home visit.
•The registered manager told us that people had access to social workers and advocates to support them when needed.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
•An assessment of people's needs was carried out before they moved into the home.
•Information obtained from the pre-admission assessment was used to develop the care plan.
•We spoke with two people who did not know what a care plan was or whether they had been asked how they would like to be cared for.
•Care records did not provide any evidence of people's involvement in decisions about their care or support.

Staff support: induction, training, skills and experience
•People were cared for by staff who had received training relevant to their role and responsibility.
•Staff told us they received an induction when they started to work in the home.
•A staff member told us, "My induction enabled me to do my job properly."
•Another staff member told us, "My induction helped me and the registered manager to find out if I was suitable to work in the home."

Supporting people to live healthier lives, access healthcare services and support
•Discussions with the registered manager and the care records we looked at confirmed people had access to relevant healthcare services when needed.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

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 people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
•We observed that people were not always supported in a way to promote their dignity. Two people were observed eating their meal with their fingers and this compromised their dignity.
•The use of a listening monitor in a person's bedroom where staff could hear them whilst they were in their bedroom was an infringement of the person's privacy. The registered manager told us they were unaware the monitor was in use and a best interest decision was not in place.

This is a breach of Regulation 10, Dignity and respect, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•One person who used the service told us that staff were very respectful and always knocked on their door before entering and we observed this.
•The same person told us they were fairly independent with regards to maintaining their personal care needs. However, when staff did support them, this was done in a private area and with dignity.

Ensuring people are well treated and supported; respecting equality and diversity
•We observed that staff were kind and attentive to people's needs. However, the lack of emphasis on protecting people from potential abuse placed people at risk of harm.
•Care records did not show how equality, diversity and human rights were promoted when delivering care and support.
•People told us they were happy living at the home and discussions with staff confirmed that people who used the service and the staff team were treated fairly regardless of their culture, sexuality or protected characteristics.

Supporting people to express their views and be involved in making decisions about their care
•The care records we looked at did not demonstrate people's involvement in making decisions about their care. However, two people we spoke with told us they were happy with the service they received.
•Where appropriate people's relatives were involved in decisions about their care.
•Staff had access to care plans to support their understanding about people's needs and how to meet them.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

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 people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
•The care records showed that various care assessments had been carried out. However, there was no evidence of people's involvement.
•Care records did not identify that equality, diversity and human rights had been explored or embedded during the assessment of people's needs. This meant people could not be confident they preference in relation to their care and support would be met the way they liked.
•One person could not remember being involved in decisions about their care and support.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
•We spoke with a staff member who was running the home in the absence of the registered manager they were unaware of AIS.
•Information was not available in different formats to promote people's understanding if and when needed.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
•Staff told us that people were offered a choice of daily social activities, but people often refused to participate. Staff were unable to demonstrate how people were encouraged to partake in activities to promote their physical and mental wellbeing.
•One person told us they occupied their time by watching the television and reading.
•We observed that very little stimulation was provided to people. Some people were asleep in their armchair, others listened to music. One person routinely walked around the home expressing to staff that they were lost.
•People were able to maintain relationships with people important to them. One person told us there were no restrictions on visiting times.

Improving care quality in response to complaints or concerns
•One record showed that a person had raised concerns. However, the records we looked at and discussions with the registered manager identified that appropriate action had not been taken to address the concern. This meant people could not be confident their concerns would be taken seriously and acted on.
•One person told us if they had any concerns they would share this with the registered manager.

End of life care and support

•At the time of our inspection the registered manager told us no one was receiving end of life care.

•Care records included people's wishes in the event of their death.

Inadequate

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
•The provider's governance to review, assess and monitor the quality of service provided to people was ineffective.
•The provider's governance failed to identify two people were at risk of potential abuse, so measures could be taken to safeguard them.
•Cleaning audits did not identify brown matter on a bed, so action could be taken to address this and reduce the risk of cross infection.
•Infection, prevention and control audits did not identify the risk of people sharing a hoist sling which, placed them at risk of cross infection.
•Medication audits to monitor the management of medicines did not identify that written protocols were not in place for 'when required' medicines to ensure all staff knew how to manage them safely.
•Staff told us they were occasionally observed when they administered medicines, to ensure their practices were safe. We observed that practices were unsafe, and people were at risk of receiving medicines that were contaminated.
•One person self-administered their medicines. The registered manager told us there were no monitoring systems in place to ensure the person took their medicines safely.
•Monitoring systems were not in place to ensure the review of DoLS that authorised the use of covert medicines were still in date or appropriate.
•Records were maintained of the amount people drank. However, there were no systems in place to monitor this, to ensure people drank sufficient amounts or what action to take if concerns were identified.
•The provider did not have monitoring systems in place to ensure all staff were involved in fire drills.
•Systems were not in place to review the use of a listening monitor that compromised a person's privacy.

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
•There was a lack of understanding regarding the duty of candour.
•Where the risk of harm to people had been identified the registered manager had not taken action to mitigate the risk.

This is a breach of Regulation 17, Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•We found that although the provider was displaying their rating within the home, their rating was not displayed on their website.

This is a breach of Regulation 20A, Requirement as to display of performance assessments, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•Since our inspection visit the registered manager has taken action to display their rating on their website.

The registered manager has a legal obligation to notify the Commission of significant incidents. The registered manager did not notify us of the allegation of abuse or where potential abuse had been identified.

This is a breach of Regulation 18, Notification of other incidents of the Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
•Quality assurance surveys were given to staff members and relatives to obtain their views about the service. We saw that comments received from these surveys were positive.
•Accessing information standard (AIS) had not been explored or embedded. Hence, the surveys given to people were not necessarily in a format people could understand to make an accurate assessment of the service they received.
•Meetings were carried out with people who used the service giving them the opportunity to tell the registered manager about their experience of using the service.

Continuous learning and improving care
•The provider had not embraced new guidance to promote the delivery of their service.
•Staff were unaware of the accessible information standards which promoted people having access to information in a format they can understand.
•Guidance in relation to 'dementia friendly' environment had not been considered.
•The registered manager was unaware of the importance of sharing information of potential abuse with the local authority team to reduce the risk of further harm to people.

Working in partnership with others
•Although the registered manager worked with other healthcare agencies to ensure people's physical and mental health needs, the registered manager was not proactive in mitigating identified risks which compromised people's welfare and safety.
•The provider worked with the local college offering work placements to students. On the day of the inspection we observed a student talking with people.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
•Two people who used the service told us they were happy living in the home and the staff were very kind.
•All the staff we spoke with said if they required care in the future they would be happy to live in the home.
•We observed that the culture of the home was warm, welcoming and friendly.
•Staff told us that as a team they worked well together in caring for people. One staff member said, "We are like one big family and we really do care for all the residents."

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
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider did not notify the Commission of significant events that had occurred within the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Care practices did not always respect people's right to privacy and dignity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Systems were not in place to review deprivation of liberty safeguards to ensure they were still required or to apply for an extension where needed to ensure restrictions imposed on people were legal.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not taken action to safeguard people from abuse.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments

The provider had not displayed their rating on their website.

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
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not taken action to protect people from the risk of harm.

The enforcement action we took:

Warning notice issued to the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's governance was ineffective to ensure systems were in place to safeguard people from the risk of potential abuse. Monitoring systems were ineffective to ensure good hygiene standards within the home. Systems were not in place to ensure all staff were involved in fire drills. The assessment of care practices did not identify the infringement of people's dignity and privacy.

The enforcement action we took:

Warning notice issued to the provider.