Touch of Care Limited

Touch of Care Limited

Inspection report

5 New Broadway
Worthing
West Sussex
BN11 4HP

Tel: 01903890943

Date of inspection visit:
10 January 2019

Date of publication:
22 February 2019

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

A focused inspection took place at Touch of Care Limited on 10 January 2019 and was unannounced. The team inspected the service against two of the five questions we ask about services: is the service well led and safe. This was following information and concerns shared with the Care Quality Commission (CQC) by the local authority. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

Touch of Care Limited 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 who are living with dementia, mobility issues and other long-term conditions such as Parkinson's, to enable them to continue living in their own homes.

By the end our inspection, no people received personal care from the service. This was due to recent emergency intervention from the local authority who reduced the number of people who used the service. The local authority had safeguarded people by providing care to people with a team of professionals and providing management support to the service after invoking their emergency policy and protocol. Some people privately funded their care whilst others had their care funded by the local authority. Following the inspection, the local authority coordinated care for people who were still with the service and worked with them to find alternative providers of care.

Before the inspection, we asked the provider for information in response to significant concerns that we received which indicated that not all people had received a safe or consistent service. We also attended strategic meetings held by the local authority involving all related external agencies.

The service is owned by a provider who is also the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the time of this inspection the registered manager was absent from the service due to being unwell. There was no registered person in charge of the day to day management and running of the service.

At the last inspection in March 2017, the overall rating was Good. Areas of improvement were identified because of a lack of formal quality assurance processes and records that related to people's care were not always complete to reflect peoples' current needs. At this inspection we found that these areas had not improved and the service had deteriorated.

The local authority shared information with the CQC that some people had not received their scheduled care calls in line with assessed needs and visit schedules. This had exposed people to the risk of harm because they depended on the calls to meet their personal care needs and check on their safety and well-

being. One person had not received the daily care calls they needed for three days. Four additional people had missed care calls. One person had not received time critical medication and a further two people had not received their medication. The local authority had safeguarded these people by providing care to people after invoking their policy and protocol. The local authority had also raised safeguarding investigations.

Staff were not recruited safely. The service had a small committed group of staff however the service did not employ sufficient numbers of care staff. Care staff were not deployed adequately to arrive at calls on time to meet people's needs. Rota's were not managed well, which meant that that calls were missed.

Records were not available to the inspection team to show how people were protected against avoidable harm and abuse. From the records that were available, risks to people were not always assessed. There were no records to show systems for monitoring the quality of care and support.

Care records were not fully completed or up to date. People's personal care needs were not always consistently assessed. People's care files were either informed by a referral from local authority, that contained the local authority's' assessment of the person's needs or an assessment done by staff of basic personal care needs but these were not always fully completed.

Electronic records and information needed for the day to day running of the service were not accessible to staff.

People's confidential information was not always kept private. For example, the local authority informed CQC that information about one person who received care from Touch of Care Ltd was found in another person's home.

We found breaches of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

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.

Recruitment practices did not always ensure the suitability of staff.

Risks to people were not assessed.

People did not always receive their medicines on time.

The service did not employ sufficient numbers of care staff and care staff were not deployed to arrive at calls on time and to meet people's needs.

Not all staff had consistently received up to date safeguarding training.

Is the service well-led?

Inadequate

The service was not well-led.

There was no registered person or nominated individual in charge of the day to day management of the service.

Care plans did not reflect of people's care needs.

No records were available at this inspection of an auditing system to monitor or improve the quality and safety of the service people received.

People's confidential information was not always kept private.

Touch of Care Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted by concerns raised by the local authority. People and their relatives also raised concerns and complaints to the local authority.

This focused inspection took place on 10 January 2019 and was unannounced. We visited the office location to review care records, staff files and other records relating to governance of the service and people's care.

The inspection team consisted of two inspectors and an assistant inspector.

Prior to the inspection, we reviewed the information we held about the service. This included recent information from the local authority and notifications sent to us by the manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection. We asked the provider for documentation, following concerns that not all people had received a safe or consistent service.

At this inspection we saw staff rota's, four staff files and 20 people's care files. Some records we would normally view at inspection were not available to us. Paper based and electronic records were not available to staff and therefore not available to the inspection team. There was no registered person or nominated individual in charge of the day to day management and running of the service at the time of this inspection.

Staff were not continuing their employment with the service and therefore we did not have detailed conversations with staff. We spoke briefly with two carers and the local authority team manager who had been in attendance to support the service during this time.

As people were in the process of being transferred to other services we were not able to speak to them

about the care they received.

Inadequate

Is the service safe?

Our findings

The service was not safe.

Due to the registered manager not being present on a day to day basis at the service and the lack of documentation available for us to review at this inspection, we could not be assured the service was safe. There were no contingency plans to ensure that staff could provide safe care to people in the registered manager's absence. The local authority was coordinating care and supporting people to identify alternative providers for their care needs.

Recruitment practices did not always ensure the suitability of staff. Risks to people were not always assessed when recruitment decisions were made. Staff we spoke to confirmed this. There were no records to show risk assessments taking place before staff started their role. References were not always obtained to show staff were of good character and there were unexplained gaps in employment history for four staff. For one member of staff there was no employment history and no references obtained. For two members of staff, criminal convictions were noted on their DBS checks that could put people at risk. There were no risk assessments in light of these concerns on new staff members DBS checks before they started their role. Therefore, the provider could not be assured that staff were of good character to provide safe care to people.

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

Risks to people were not assessed or recorded. At this inspection no records were available to show that risks to people were assessed. There were no records to show systems for monitoring the quality of care and support.

Local authority shared information with the CQC that some people had not received their scheduled care calls from 19 December 2018. The provider did not notify the CQC of these missed calls. This had exposed people to the risk of harm because they depended on the calls to meet their personal care needs and check on their safety and well-being. By not providing care calls in line with assessed needs and visit schedules, people were placed at risk of harm. One person had not received the daily care calls they needed for three days. An additional four people had missed care calls.

The local authority shared information with us that for one person, care calls were sometimes an hour late, soiled bed sheets were not changed and a night bag for a catheter was not being used (limiting the amount of urine that could be contained within a smaller, daytime bag). A catheter is usually used when people have difficulty urinating naturally. A urinary catheter is a flexible tube used to empty the bladder and collect urine in a drainage bag.
The person's needs had not been safely met by the provider.

Medicines were not always managed safely and we found some concerns related to medicines

management. The local authority told us that people did not always receive their medicines on time. One person had not received time critical medication they needed due to missed calls. This placed the person at risk because it was important that their medicines were taken on time to manage their condition safely. A further two people had not received their medication.

People did not have any medication care plans or medicines assessments. Staff did not have access to guidance about a person's preferences and did not know how they like to take their medicines. One person had a record of a daily medicine given in their care records but this did not state what medicine was given and did not include a signature of the staff member responsible for the care given. Therefore, there was no evidence that the person had received their medicine as prescribed.

Staff files showed that some staff had received medicines training but there were no records to show how staff competency was checked or monitored to ensure they gave medicines safely to people.

Some people's daily care records showed the personal care support they had received from staff. One person had daily food and fluid intake and bowel movement records for a period of three weeks. The bowel movement record showed no bowel movement for 10 days, the recording was not consistent every day and records did not show if action was taken or why the person's fluid, food and bowels were being monitored. This may have placed the person at risk if appropriate medical intervention was not sought if needed.

Local authority shared information with us that a person was subsequently admitted to hospital after a missed call from the provider. There were no care records or paperwork at the person's home to share with the hospital. The person had been placed at risk through no care records being at their home to inform hospital staff of their conditions and needs.

The service did not employ sufficient numbers of care staff and care staff were not deployed adequately to arrive at calls on time. The service had a small group of committed staff. The way work was allocated to staff was not effective and presented a risk that calls would be missed or sufficient staff would not be rostered.

The provider had failed to assess, record and mitigate risks to people's health and safety and the lack of proper and safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On inspection there were no records showing how the provider learnt and improved when things had gone wrong. Records were not available to the inspection team to show how people were protected against avoidable harm and abuse. There were no records to show systems of recording accidents, incidents or raising safeguarding concerns to external agencies. Staff files showed that only two staff had attended training in safeguarding vulnerable adults. We also found inconsistencies with health and safety training.

Inadequate

Is the service well-led?

Our findings

The service was not well-led.

At the last inspection in March 2017 the key question Well-led was rated as Requires Improvement. The last inspection identified a lack of formal quality assurance processes and records relating to people's care were not always complete or up to date reflecting peoples' current needs. At this inspection we found that these areas had not improved and the service had deteriorated.

At this inspection, Touch of Care Ltd did not have a registered person or nominated individual in charge of the day to day management. The service was owned by a provider who is also the registered manager. At the time of our inspection the registered manager was not managing the service due to an extended period of absence due to ill health.

Due to the lack of management, a number of staff had left. The local authority told us staff were "over loaded" with work and the needs of people could not be met by the staff who were left.

Due to the lack of management, no records were available on inspection to evidence that an auditing system was used which could monitor and improve the quality and safety of the service delivered to people.

There was no formal list of the people who received care from the service. The manager had not made arrangements for the governance of the service or day to day coordination of people's care in their absence. Staff did not have the skills or knowledge required to continue the day to day running of the service. Electronic records and information needed for the day to day running of the service were not accessible to remaining staff.

Care records were not adequately completed. People's care files were either informed by a referral from local authority when the person joined the service, showing the local authority's' assessment of the person's needs or an initial assessment done by staff of a person's basic personal care needs.

People's confidential information was not always kept private. For example, local authority informed CQC that information about one person receiving care from Touch of Care Ltd was found in another person's home.

Staff files did not consistently reflect ongoing training and development. There was no structured training plan or system to identify training needs. There was some limited evidence in records that showed staff received appraisals and had spot checks to review their competence but these spot checks were not specific to areas of practice such as to the safe management of medicines. One staff file noted that a staff member had agreed to change their moving and handling practice but there was no extra support, agreed actions or additional training offered.

The provider had not effectively sought feedback from people, their relatives and professionals to improve

service provision. There were records of two people being asked for feedback about the service in 2017 where people had not raised concerns but there was no evidence to suggest this had been done since nor that feedback gathered had been reviewed and analysed.

The care staff who remained had worked with the local authority to continue to deliver care to people and communicated with people about the recent changes in the service.

Due to the lack of a manager present and the fact that staff could not access electronic records, from the evidence we saw within the paper records available on inspection, there was no evidence of a culture of learning, reflective practice or service improvement.

The provider had failed to put in place appropriate contingency plans. Staff were not supported to carry out their role. Records were not accurate, complete, up to date or accessible to staff when required. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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	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 proper and safe management of medicines.

The enforcement action we took:

Following this inspection, a notice of decision was served under Section 31 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This imposed a condition on the registration as a service provider to not take on any care packages to provide the regulated activity, personal care, to people without the prior written consent of the Care Quality Commission.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Staff were not being equipped to continue the day to day running of the service in the manager's absence. There were concerns that 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. Records were not always maintained or kept secure.

The enforcement action we took:

Following this inspection, a notice of decision was served under Section 31 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This imposed a condition on the registration as a service provider to not take on any care packages to provide the regulated activity, personal care, to people without the prior written consent of the Care Quality Commission.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe recruitment practices were not always followed.

The enforcement action we took:

Following this inspection, a notice of decision was served under Section 31 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This imposed a condition on the registration as a service

provider to not take on any care packages to provide the regulated activity, personal care, to people without the prior written consent of the Care Quality Commission.