Total Homecare (Yorkshire) Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

At the time of the inspection, the location did not care or support anyone with a learning disability or an autistic person. However, we assessed the care provision under Right Support, Right Care, Right Culture, as it is registered as a specialist service for this population group.

About the service
Total Homecare (Yorkshire) Limited is a domiciliary care service providing personal care to people living in their own houses and flats. At the time of our inspection there were 70 people using the service.

People's experience of using this service and what we found

Right Support:
Although the provider had systems in place for call monitoring, there was no overview of this, and we identified a number of issues with call times and length of calls which had not been picked up by the provider. Care documentation lacked evidence of assessment of people's needs. People's choices were generally promoted by staff who had a good understanding of how to promote people's independence.

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 supported this practice.

Right Care:
Care documentation did not always give staff good information about what to do to promote people's safety and protect them from avoidable harm. Records did not demonstrate medicines were managed safely. Care records needed additional information to help staff get to know and understand the person they were supporting. People did not always feel as though they had been supported in making decisions about their care or being involved in the care planning process. Staff knew what to do to make sure people's privacy and dignity needs were met and some people gave us examples of the good care they, or their relative had received.

Right Culture:
The provider did not have a system in place to monitor safety and quality within the service. This meant they were unaware of issues happening in the service and therefore were unable to take learning from them. We identified issues in relation to staff recruitment, call monitoring and medicines management. People who

used the service and staff felt supported by the registered manager.

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 2 October 2018). The rating for this inspection has now changed to requires improvement.

Why we inspected
This inspection was prompted by a review of the information we held about this service and the date of the last inspection.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Total Homecare (Yorkshire) Limited on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment and governance at this inspection.

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

Special Measures
The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

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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 Health and Social Care Act 2008.

Inspection team
The inspection was carried out by 1 inspector, an assistant inspector who made calls to staff and an Expert by Experience who made calls to people who used the service and their relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of 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.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because the service is small and people are often out and we wanted to be sure there would be people at home to speak with us.

Inspection activity started on 21 April 2023 and ended on 15 May 2023. We visited the location's office on 24 April 2023.

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 and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider had completed a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 2 people who used the service and 7 relatives about their experience of the care provided. We spoke with 7 members of staff including the registered manager and the deputy manager. We reviewed a range of records. This included 7 people's care records and multiple medication records. We reviewed a variety of records relating to the management of the service, including policies and procedures.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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.

Staffing and recruitment

- Staff were not always recruited safely.
- Checks on the suitability of staff to work with vulnerable people had not always been completed before staff started work. We saw 2 members of staff had carried out unaccompanied visits to people before the provider had received the outcome of their DBS checks. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
- Appropriate references had not been obtained for the 3 staff whose recruitment records we checked. We also noted files for staff who used their cars, did not always include copies of the person's driving license or insurance details.
- An electronic call monitoring system was in place. The system was designed to show if the calls were made on time, when the staff member left the call and when the staff member had completed tasks. However, our review of this system showed calls were not always made at the planned time and varied significantly in the times staff spent on the call. For example, a person whose calls should have been for 30 minutes had call times recorded as short as 4, 5 and 6 minutes.
- People's records showed staff had failed, on many occasions, to log in and out of the call. For example, one person's care records for a period of 1 month showed staff had failed to log in on 19 occasions and failed to log out on 33 occasions. This meant the length of the call was unknown.

The provider had failed to ensure safe systems were in place in relation to monitoring the safe recruitment of staff and monitoring of calls made to people and had failed to implement effective systems to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some of the people we spoke to were happy with their call times although some commented staff were sometimes rushed or didn't stay for the planned time. One person told us, "Their timekeeping has been one of the best, although when they have a lot on, they can't always stay the (allotted) time. The carer they sent last Saturday was doing a 14.5hr day. They just don't seem to have enough staff."

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks to people's health and safety were not always assessed. One of the 2 paper-based care files we looked at included some risk assessments, but we could not be assured these had been reviewed for over 3 years. None of the electronic care records we looked at contained any risk assessments. This meant that staff would not be aware of how to mitigate risks to people from, for example, the environment care was to

be delivered in, equipment used or risks to people's personal risks such as choking.
● The provider did not have a system in place for monitoring and auditing quality within the service. This meant they did not have an overview of where things might have gone wrong and identify what lessons could be learned.

The provider had failed to make sure risks to people using the service had been assessed and reviewed. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Medicines were not managed safely.
● One person's relative had made the provider aware of a new medication to be administered by staff. The medicine was not administered until 3 days later.
● One person's medication administration record (MAR) showed staff had, on several occasions, used the recording code to indicate no visit had taken place when the medicine was to be taken. Records showed the visits had taken place.
● When medicines had not been administered, an alert was created on the electronic care system. However, there was no evidence of what had been done to address the alert. One person's records showed 13 alerts over a 5-day period.

The provider had failed to make sure people received their medicines safely. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were protected from abuse and poor care.
● One relative told us, "The carers are very good with him and keep him safe enough to continue living at home" and another said, "(Person) feels very safe with the carers and they have been helping (them) to walk using (their) stick. They are all very encouraging as (person) makes progress. They have played a big part in that."
● Some relatives expressed concern that care staff did not always understand their family members needs in relation to their dementia and felt they did not always encourage their family member to accept the care they needed. However, another relative told us, "They (carers) don't give up on (person) and are always really good with (person). They understand (their) dementia."
● Staff had received safeguarding training and understood when and how to report abuse.

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 MCA 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.
When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.
●The registered manager told us if they were concerned a person lacked capacity, they would request an

assessment be completed by a social worker. Where people had a lasting power of attorney in place, the registered manager obtained a copy for the person's records. The registered manager understood about the best interest decision process for people who lacked capacity.

- Care records did not include information about people's capacity.
- Staff understood the principles of the MCA.

Preventing and controlling infection

- Some people said staff wore personal protective equipment (PPE) such as aprons, gloves and masks appropriately. However, one person's relative told us, "We had to keep on and on at them for a long time about not wearing their PPE and we got a lot of pushbacks (excuses) from carers as to why they didn't wear it. We even had to push for a change of gloves between tasks." Another person's relative said, "Not all carers will wear PPE. I'm always having to ring the office and complain."

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 and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed 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; Continuous learning and improving care; Working in partnership with others

- Since the last inspection a new registered manager was in place.
- The registered manager and provider did not have any systems in place for monitoring and auditing safety and quality within the service. This meant the provider was unaware of issues we found in relation to care records, managing medicines safely and staffing.
- The electronic care records system produced an overview of, for example, missed or late calls, care tasks completed and medication administered. However, we did not see any evidence of the provider or registered manager having analysed this overview to identify any potential issues.
- One person's relative told us, "I am not actually sure they (office staff) know what the carers are doing. They seem to chop and change calls amongst themselves. I wonder if they are actually logging in?"

The provider had failed to implement effective systems to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff worked with health and social care professionals such as GPs, district nurses and social workers to support people in meeting their health and social care needs.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The registered manager had recently sent out quality assurance surveys to people and their relatives to give them the opportunity to feedback about the support they received. No responses had been received at the time of our inspection.
- None of the people we spoke with told us they had been asked for their opinion of the service. Some people felt the service reacted well initially when they raised concerns but did not always think any improvements were sustained. However, other people told us, "If I do ring the office, they do listen to me and things change. I think they are a good bunch there" and "I have complained to the office when the less thorough carers don't do the basic stuff. They are fantastic and will take constructive criticism as they steer their carers in the right direction."
- Staff felt well supported by the registered manager.

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 understood their responsibilities to be open and honest with people when things went wrong. Although they had not made record of instances, they were able to give us examples of when they had investigated issues and made an apology to the person or their family.

● Some of the people we spoke with told us how the registered manager had followed up on concerns. One said, "We did complain and we got an apology" and another told us, "I think the manager is good and will follow through on promises."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure risk was assessed and managed. The provider failed to ensure medicines were managed safely.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure governance arrangements were in place which meant people were at risk of receiving poor care.