Terrablu Limited

TerraBlu Homecare

Inspection report

9 Calverley Park Crescent
Tunbridge Wells
Kent
TN1 2NB

Tel: 01892529429
Website: www.terrablu.co.uk

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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
TerraBlu Homecare is a domiciliary care service providing personal care to people living in their own homes. Not everyone who used the service received personal care. The Care Quality Commission (CQC) only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. The service was providing personal care to approximately 40 people at the time of the inspection. Most people receiving care were older people and people with physical disabilities. The service was providing care for one person with a learning disability and autism.

People's experience of using this service and what we found
Most people and relatives gave us positive feedback about their care and support. They told us, "They are very careful with me, I've never had an accident and I feel very safe with them"; "From the first phone call they have been brilliant"; "I know all my carers now and they are extremely good"; "We have a regular carer who is well trained and extremely good at her job and likes it. She takes great care and does all the things [person] likes even down to turning his trouser legs up for him because she knows he likes it that way"; "They have kept me very safe, they wear masks even now so they are very good" and "Our main carer seems to know exactly what she's doing and has suggested things that will help too."

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The management team were not aware of Right support, right care and right culture. Based on our review of safe and well-led, the service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right support
Staff supported people to complete personal care tasks and activities to meet their assessed needs set out in the care plan. However, care plans for people with a learning disability and or autism were not structured to support people to achieve their goals and aspirations.

Right Care
The provider did not have effective safeguarding systems in place to protect people from the risk of abuse. Safeguarding concerns related to older people had not always been reported to the local authority. Staff understood how to protect people from poor care and abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

Right culture
People and those important to them, including advocates, were involved in planning their care.

Individual risks were not always assessed and managed to keep people safe. Care plans were in place. However, care plans and risk assessments were inconsistent and did not always detail the relevant information staff would need to meet people's assessed care and health needs. People could not be sure their prescribed medicines were always managed in a safe way. When people had accidents and incidents, appropriate reports had not been completed.

People could not be assured new staff were adequately checked and had received training to ensure they were suitable to work with people to keep them safe. We found no evidence that people had been harmed however, systems were either not robust enough to demonstrate staff recruitment was effectively managed.

The systems in place to audit the quality of the service were not robust or sufficient to alert the provider of the concerns and issues within the service. Audits had not picked up areas which were identified during the inspection. Registered persons had failed to notify CQC of incidents and events such as abuse and serious injuries.

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

Rating at last inspection
The last rating for this service was good (report published 30 December 2017).

Why we inspected
We received concerns in relation to recruitment practice, staff training and the management of medicines. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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 based on the findings of this inspection. We have found evidence that the provider needs to make improvements. 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 TerraBlu Homecare on our website at www.cqc.org.uk.

Enforcement and Recommendations
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 and will take further action if needed.

We have identified breaches in relation to medicines management, risk management, safeguarding people from abuse, recruitment practice, quality monitoring and notifying CQC of events and incidents.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is

added to reports after any representations and appeals have been concluded.

Follow up
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?

Requires Improvement

The service was not always well-led.
Details are in our well-led findings below.

TerraBlu Homecare

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 two inspectors and an Experts by Experience spoke with people and 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.

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
This inspection was unannounced. We visited the office location on 09 February 2022. Calls with people and relatives were made on 11 February 2022. Calls with staff were made on 16 and 18 February 2022.

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 who commission the service. We also sought feedback from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. Healthwatch told us they had not visited the service or received any comments or concerns since the last inspection. A local authority commissioner told us they had not received any concerns about the service.

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with seven people who used the service and six relatives about their experience of the care provided. We received written feedback from two people/relatives through our website. We spoke with 11 members of staff including care staff, senior care staff, the deputy manager, the operations manager, the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included six people's care records and multiple medicines 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 audits, risk assessments, complaints records, surveys and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance 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 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.

Systems and processes to safeguard people from the risk of abuse

- The provider did not have effective safeguarding systems in place to protect people from the risk of abuse. Safeguarding concerns had not always been reported to the local authority. Two people had reported to the registered manager that a staff member had stolen from them. The registered manager had not reported this to the local authority following the local authorities safeguarding protocols, policy and procedures.
- The management team lacked awareness of what action they should take in response to allegations of abuse, such as physical abuse and financial abuse. The provider's safeguarding policy demonstrated a lack of understanding and conflicted with the local authorities safeguarding protocols, policy and procedures.
- Staff we spoke with were confident they would be able to identify abuse. They told us they would report safeguarding concerns to the management team in the office. Staff lacked awareness of their responsibility to report actions outside of the organisation if the management team had not acted to protect people from abuse and mistreatment.

The failure to protect people from abuse and improper treatment was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Despite the findings above, people told us, "I am definitely safer with the carers coming. I have an awkward shower which I could have changed but I don't want the trouble, my mobility isn't good and I really need them and they are very helpful" and "I feel much safer with the carers, I have a tendency to stumble or get a bit dizzy so washing is much better with the carers here."

Assessing risk, safety monitoring and management

- There were risk assessments in place to provide guidance to staff on how to support people. However, these were not always clear, detailed and robust. Some people had been assessed as at risk of falls. Their risk assessments did not provide details to staff about what action they should take if the person fell and did not detail that people were prescribed anticoagulant medicines that put the person at increased risk if they fell. This meant staff did not have all the information they needed to provide safe care.
- People living with diabetes had care plans in place which detailed their diagnosis. However, the care plans and associated risk assessments did not provide clear guidance for staff on how diabetes affected the person and what action staff should take if the person showed signs of high or low blood sugar levels. There was no clear information about what the signs of high or low blood sugar levels may be. This meant staff did not have all the information they needed to provide safe care.
- Some care plans and associated risk assessments were very detailed and clear. For example, risk

assessments for people who had been assessed as needing a hoist and sling to transfer safely detailed how to safely do this and what loops to use on the sling to ensure the person was safe. This evidenced there was inconsistent practice in relation to risk management across the service.

Individual risks relating to the health, safety and welfare of people and staff had not been robustly assessed. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Before we inspected, we received a concern about safe recruitment practice, induction and training. We found that staff were not always recruited safely. Staff recruitment records showed gaps in staff employment history. These gaps had not been addressed and recorded. This meant the provider was not able to demonstrate that they had a full employment history for each employee as required by Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Training records evidenced that staff did not complete the provider's mandatory training before they commenced their shadowing shifts, induction and work. This could lead to staff not fully understanding their roles. People and relatives shared that some carers lacked awareness of people's wants and needs. One person said, "I think they do a lot of training on the computer which doesn't teach some things." Another person told us, "A few times someone has come with no hoist (standing hoist) experience and I have had to talk them through this." One relative wrote to us to state, 'Only one carer came to my wife who should have two carers. The carer didn't know how to use the hoist, so my wife had to stay in bed all day.'

A robust approach to recruitment was not taken make sure only suitable staff were employed, with the right competence, skills and experience to provide care. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Disclosure and Barring Service (DBS) criminal record checks were completed as well as reference checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

● The provider informed us of workforce pressures affecting the service, this had prevented them from taking on some packages of care and had meant that some people's care and support had been altered because of staff availability. People and relatives shared with us that they often did not know which staff member was coming to provide care and support and when they would arrive. They felt communication should be improved.

● People and relatives gave us mixed views about this. Comments included; "I don't know who is coming unless the previous carer looks on their chart, we don't have a rota and they will be changing to computers so I am not sure how that will work"; "The rotas are done on a Monday for the week so it we don't get a rota for [loved one] and we would like one ahead of time so we know exactly what is happening"; "They are usually good with time unless they have an unavoidable problem. Sometimes in the evening they are in a hurry when they come"; "They always come in good time in the mornings now but sometimes other times are not so good and they arrive when I'm not expecting them"; "The carers arrive when they are supposed to and they don't rush, they look for other things to do if they have finished and they have a chat. I always notice the difference when the carers have been" and "TerraBlu have been very stretched lately so the times of calls are all over the place. They always turn up but don't always let me know. It impacts on me as I can't get on with my day and have a shower until he has had one as I don't want them turning up whilst I am in the shower."

Using medicines safely

● Medicines were not always well managed. Medicines administration records (MAR) were not always complete, accurate and clear. MAR records did not list which medicines staff were giving. Instructions were noted 'Dossett box medicines – list in risk assessment x 7 tablets in the morning'. Staff had signed to show the medicines had been given and how many. One person's MAR showed that staff had been giving a different amount of medicines to what was listed on the MAR. Another person's MAR had missing dates and gaps. This meant it was difficult to verify if people had received their medicines safely and as prescribed.
● Medicines audits were not completed frequently enough to identify issues such as missed signatures, changes in dose and other concerns. The last medicines audit had been completed in May 2021.
● The provider's medicines policies and procedures were not always followed. The provider's medicines policy stated 'Terrablu will not support medicine which has been dispensed into a compliance aid by a family member or friend.' A staff member told us they administered medicines that had been dispensed into compliance aids by family members as well as the pharmacy. The provider's medicines procedure stated that comprehensive records needed to be maintained which included specific guidance about full medicines names, strengths and doses to be included on the MAR. The provider's medicines procedure also stated, 'Each medication must be entered on the MAR chart individually even if the medication is supplied in a multi-dose monitored dosage system prepared and sealed in pharmacy.' This meant that the provider could not be assured that medicines had been given as prescribed.

The failure to take appropriate actions to ensure medicines are managed in a safe way is a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Preventing and controlling infection
● Staff had access to enough personal protective equipment (PPE). Staff collected PPE and lateral flow COVID-19 tests from the office during the inspection. The provider had introduced a testing regime to test staff to identify their status of COVID-19. Records were retained of which members of staff had been tested. The management team told us staff had received COVID-19 specific training to understand how to out on and take off their PPE in April 2020. Recruitment records showed that new staff had been recruited since that date, this meant that newer staff had not received the COVID specific training. This is an area for improvement.
● Risks to people from infection were managed to ensure they were minimised. The provider ensured people were protected by the prevention and control of infection.
● We were assured that the provider's infection prevention and control policy was up to date. Staff had completed the relevant training. All care staff had received the appropriate training to learn how to minimise the risk of infection spreading.
● People and relatives told us staff wore PPE to keep themselves and people safe. Comments included; "They always come wearing the right things like masks and gloves, I've felt very safe", "They have kept me very safe, they wear masks even now so they are very good", "They have been all masked up with gloves and sanitisers and kept [loved one] safe during COVID" and "We had no issues with the care during COVID, they used masks and sanitisers and followed all the guidelines."

Learning lessons when things go wrong
● There was a system in place in relation to accidents and incidents. There were no accident or incident records relating to people to view. The deputy manager told us there had not been any. However, during the inspection the provider sent a notification of an incident through to CQC which evidenced that there had been accidents and incidents to people. One person had fallen and injured themselves in January 2022 and had been found by a staff member. This had not been appropriately recorded. This is an area for improvement.

● Staff accidents and incidents had been recorded and logged and actions had been taken. For example, staff had been bitten by a dog during their care calls with a person. The management team had asked for the dog to be kept in a different room to mitigate the risks of this happening again. The person and their relatives had refused so they had no other option but to terminate the package of care.

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

- The systems in place to audit the quality of the service were not robust or sufficient to alert the provider of concerns and issues within the service. Audits had not picked up shortfalls in practices in relation to risk assessment, safeguarding, medicines management, staff recruitment, training, care planning, recording and notifications of events.
- Audits had not taken place frequently enough to give the management team full oversight. The last medicines audit had taken place in May 2021.
- Records were not returned to the office frequently enough to enable the management team to monitor and check that care and support had been delivered to meet people's assessed needs. Medicines records from December 2021 had been returned to the office for checking but had not yet been checked. This meant that the management team were not aware of the concerns in relation to recording until the inspection identified the issue.
- Some people and relatives told us they did not know who was running the service. Comments included, "I think it was the manager who came to do the assessment, they were easy to talk to and gave a phone number and said, just ring if any problems"; "I don't know the manager but the office are very good though" and "I'm always on the phone to them, the people in the office, no I don't know the manager. The office people are very patient and very tolerant of me, I'm constantly changing times and things and they are always very nice to me."

The provider had failed to operate a robust quality assurance process to continually understand the quality of the service and ensure any shortfalls were addressed. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Registered persons are required to notify the Care Quality Commission (CQC) about events and incidents such as abuse, serious injuries and deaths. CQC had not received any notifications from the service in a 12-month period. The provider and registered manager told us they understood their role and responsibilities. However, they had not notified CQC about all important events that had occurred and had not met their regulatory requirements because one serious injury, one death and two allegations of abuse had not been reported to CQC when they had occurred.

The failure to notify CQC in a timely manner about incidents that had occurred is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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

● There was a registered manager at the service who had oversight of the day to day running of the service. The registered manager and deputy manager regularly carried out care visits to people to support the staff team and to carry out observations of care carried out by care staff.

● People and relatives told us their care involved them and enabled them to live independently. Comments included, "I do know my carers, they are very good, they help me get up and go to bed and go for walks and they walk me to the hairdressers. I wouldn't change anything" and "We had a very thorough assessment, all the triggers and likes and dislikes and it was all communicated to the team and it's not just a tick box, they talk to him about the things he likes."

● The service had received written compliments. One recent one read, 'We used TerraBlu to help my mum who has Alzheimer's. From the thorough initial assessment to the carers visits, TerraBlu were fantastic. The carers treated her with dignity, respect and brightened up the days with their visits. They were totally understanding of mum's needs and nothing was too much trouble for them.'

● Staff told us that the culture within the service was open and transparent. One staff member said, "There is a supportive culture, most of the time it is quite good, the team are pretty good to me."

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

● When there had been complaints about the service, the management team had investigated complaints, met with people and their relatives as part of the complaints investigation and written to people and relatives with an outcome. One person confirmed they had made a complaint and said "[Nominated individual] sorted it out in the end and we were happy with the outcome." Complaints procedures and other information for people using the service were not available in easy to read and accessible formats to help people with learning disabilities and others understand them. This is an area for improvement.

● It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. The provider had displayed a copy of their rating on their website and in the office.

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

● People and relatives gave us mixed feedback about communication from the service. Some people commented that they received good communication and knew when staff were coming to provide care. Other people and relatives did not have the same experiences. One person told us, "I asked for a 08.00am call and at first I was getting calls at 07.00 am or 07.30 am, it's better now but they never call if they are going to be late." This is an area for improvement.

● People and relatives told us they received surveys to enable them to provide feedback. One relative said, "We had an email checking the service we are getting is what we want and asking for feedback." A person told us, "We have a feedback survey regularly and they do come back to us if there are any issues raised." Survey results from 2021 showed positive feedback from people. The surveys also showed staff felt well supported and confident regarding infection control. The management team had just sent out surveys for 2022 and were in the process of collating responses. The provider had planned a 'client forum' for March 2022 to enable people to come together and provide face to face feedback.

● The management team had also used group chat messages and computer software to ensure effective communication and to ensure all staff got information at the same time. Staff felt the office staff and management team were approachable. One staff member said, "I find the office staff easy to talk to, I can discuss any issue. They are always supportive. It's like a family, relationship and communications between

office and care workers is usually pretty good." Other comments included, "I am on the phone a lot to the office, nothing is too small for them to deal with" and "There is a good culture, supportive and we are made to feel appreciated. We are given regular updates and able to report any problems."

● Staff meetings had continued to take place regularly to enable staff to discuss important information. Staff told us meetings took place through video calls during the pandemic.

Working in partnership with others

● The management team worked closely with the health care professionals such as community nurses and people's GPs. The registered manager explained that they had engaged with support from outside the organisation such as Skills for Care and had signed up to the CQC newsletter to ensure they kept up to date with changing guidance.

● Other members of the management team planned to sign up to other external support agencies to enable them to effectively manage the service such as Skills for Care and local authority manager forums.

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 18 Registration Regulations 2009 Notifications of other incidents Registered persons had failed to notify CQC in a timely manner about incidents that had occurred. Regulation 18 (1)(2)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Registered persons had failed to adequately assess individual risks relating to the health, safety and welfare of people and staff. Registered persons had failed to take appropriate actions to ensure medicines were managed in a safe way. Regulation 12 (1) (2)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The failure to protect people from abuse and improper treatment was a breach of Regulation 13 (1)(2)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate a robust quality assurance process to continually

understand the quality of the service and ensure any shortfalls were addressed. Regulation 17 (1)(2)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed A robust approach to recruitment was not taken make sure only suitable staff with the competence and skills were employed to provide care. This was a breach of Regulation 19 (1)(2)(3).