Better Healthcare Services Ltd

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
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.

About the service
Better Healthcare Services is a domiciliary care service registered to provide the regulated activities of personal care and treatment of disease, disorder or injury to people living in their own homes. Not everyone who used the service received regulated activities. CQC only inspects where people receive regulated activities. For people who receive care from this provider, this is help with tasks related to personal hygiene, eating and treatment of disease, disorder or injury which should be overseen by an appropriate health professional. Where they do we also consider any wider social care provided. At the time of our inspection, there were 24 people receiving regulated activities.

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

Right Support
People did not always have current care plans to meet their health and well-being needs and manage risks. The provider did not ensure people always received their medicines safely.

Right Care
The provider had not ensured all safeguarding concerns were shared with CQC. People did not always receive their care at the right time or for the right duration, and the provider had not monitored this. People did not always have their treatment effectively overseen by a medical practitioner, which increased health-related risks to them.

Right Culture
There was not always a positive culture in the service, as staff did not always feel well supported by the provider. Lessons could not always be learnt from accidents and incidents as these were not always recorded. There were no established systems and processes for the provider to maintain quality standards and to continuously improve the service people received. However, the staff did feel supported by the manager, and there were systems in place to seek regular feedback from people, relatives and staff.

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 requires improvement (published 2 April 2020).

Why we inspected
This inspection was prompted by a review of the information we held about this service. 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 requires improvement to inadequate. 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 Better Healthcare Services on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to people's safety and good governance at this inspection. 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 work alongside the provider and local authority to monitor the service and continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore 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 rating, 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.

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.

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.

Better Healthcare Services

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
This inspection was carried out by 1 inspector. An Expert by Experience also spoke to relatives on the telephone about their experience of the care provided. 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 homes.

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 not a registered manager in post.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the provider would be able support the inspection. Inspection activity started on 19 June 2023 and ended on 27 June 2023. We visited the location's office on 26 and 27 June 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. 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 1 person who used the service. We spoke with 6 relatives about their experience of the care provided. We spoke with 6 staff including, care workers, a senior care assistant, the field care supervisor, the care coordinator and the manager. We reviewed 6 people's care records. We looked at 3 staff files in relation to recruitment practices. We reviewed various records relating to the management of the service including training records, safety checks, incidents and accidents.

Inadequate

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 requires improvement. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

- People did not always receive their medicines safely.
- Medication administration records (MARs) were not always signed by staff to confirm people had received their prescribed medicines. This increased health related risks to people who may not have received their prescribed medicines.
- MARs did not always contain accurate information. We found errors in how medicines were spelt, an incorrect address and people's allergies were not always fully listed. Good practice was not followed for MAR to be checked and signed by 2 staff members before use. This increased the risk of errors and people receiving their medicines incorrectly.
- Best practice was not followed to ensure people had protocols for medicines taken 'as required' (PRN). This meant staff did not have guidance to ensure people could receive their PRN medicines when they needed it.
- Medicines audits were undertaken but ineffective. Errors such as staff who had signed to state a person had received a medicine when it was no longer in stock had not been identified by the provider. This meant measures could not be put in place to reduce the risk of the same thing happening again.

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

- Risks to people were not always well managed.
- Daily records showed staff had not recognised and appropriately responded to potential medical emergencies. We reviewed a person's records of care and found staff had not sought medical advice when they experienced epileptic activity that was more prolonged and differed on how the condition usually presented for them. This exposed this person to significant health risks and harm.
- The manager and 2 staff members we spoke with felt it was not always safe for staff to care for people with more complex health needs. This is because they recognised they were not medically trained and some people lived with health risks which were, at times, beyond their skill and expertise. This meant we were not assured staff caring for people always had the skills, competence, knowledge and confidence to care for people safely.
- The provider had not ensured care plans and risk assessments for people living with complex health-related needs were regularly reviewed. We found a person's care plan had not been reviewed since March 2022 and another person's since November 2021. This increased health and safety risks to people as staff did not always have current guidance to meet their needs.
- The manager told us since a nurse left in 2022, the provider had not arranged for another medical practitioner to regularly oversee the day-to-day care of people requiring treatment. Although the provider employed medically trained staff such as nurses in other parts of their business, they could not effectively

oversee incidents and health concerns relating to these people as incidents were not always recorded on the provider's electronic recording systems. This means incidents could not be continually reviewed by appropriately trained staff who could apply their specialist knowledge in managing risks to people's health.
● Care plans and risk assessments did not always give staff the guidance they needed to manage specific risks to people. For example, a care plan did not inform staff on how much a person's drink needed to be thickened to manage choking-related risks. Another person's risk assessments were not fully completed and did not contain information such as managing mobility and medicines related risks. This meant the provider had not always ensured risks to people were assessed and managed, increasing health and safety-related risks to them.

Systems and processes did not ensure people always received safe care and treatment. The provider had failed to always mitigate risks relating to people's medicines, health and safety. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● The provider referred safeguarding concerns to the local authority, but they did not always made CQC aware of allegations of abuse. This is covered more in the well led section of this report.
● Staff received safeguarding training and knew how to report safeguarding concerns. For example, 1 member of staff told us in relation to reporting safeguarding concerns, "I would inform the manager." We then asked them what they would do if the provider did not respond appropriately to their concerns. They responded, "I'd call the police or CQC."

Staffing and recruitment
● Records showed staff did not always stay for the full duration of their care calls. We also found that staff had not documented why they had left early. Before our inspection, the provider was not aware of this. This meant the provider could not assure themselves people always received the right care for the right duration. In addition, a relative told us, "Thing is, they don't stay long enough, like yesterday (person) couldn't have a shower. Staff say 'We cannot stay, we are too busy.'"
● The manager told us improvements were needed to how new staff were recruited. The manager told us the provider used an external recruitment agency that did not give candidates all relevant information about roles, contributing to a higher staff turnover. The manager and staff told us they would prefer to do their recruitment in the branch to promote continuity of staffing for people. However, they had not had a response from the provider when they had raised this with them.
● Recruitment processes meant staff had appropriate pre-employment checks before commencing their roles. This included obtaining references from previous employers and Disclosure and Barring Service (DBS) checks. DBS checks provide information, including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection
● Staff told us they always had access to personal protective equipment (PPE). The provider stored supplies of PPE in the office and staff were able to restock their supplies whenever they needed to.
● The provider's infection prevention and control policy was up to date and promoted good practice.

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.

Continuous learning and improving care

- Systems and processes to ensure people received their medicines safely were inadequate. Records showed staff and managers had approved medicines audits without identifying medicines concerns we found during this inspection. This increased the risk of lessons not being learnt from medicines-related errors and people being placed at risk of physical harm from unsafe medicines practices.
- The manager told us the provider did not undertake any quality audits to maintain good practice and acceptable standards of care. Furthermore, the manager told us in the previous year that the provider had started to conduct an audit, but the staff member responsible for this left halfway through and the audit was never completed. This meant we were not assured the provider operated robust quality assurance processes to drive continuous service improvement.
- The provider did not always operate effective systems to support staff to obtain further qualifications. Two staff members told us the provider had made commitments to enrol them on diplomas relating to their role 2 years ago, but this had never materialised. A staff member told us, "I feel like we are given empty promises." The manager told us they, too, had been waiting to commence a Diploma since August last year, and the provider had failed to progress this. This meant staff were not always well supported with their continuous professional development and learning.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Systems and processes to ensure people received their medicines safely were inadequate. Records showed staff and managers had approved medicines audits without identifying medicines concerns we found during this inspection. This increased the risk of lessons not being learnt from medicines-related errors and people being placed at risk of physical harm from unsafe medicines practices.
- The provider did not have established systems to ensure people received care calls at the correct time and for the correct duration. In addition to our findings relating to staffing, a relative told us, "Last week, one of the carers lied about when she arrived and the time she left, which is silly because I have cameras at the back and front of house." Lack of effective care call monitoring increased the risk of people's care and well-being needs not being met. Furthermore, there was an increased risk the provider was not correctly delivering care in line with what they were commissioned and funded to deliver.
- The provider did not operate effective systems to ensure all care plans were reviewed and updated when managers did not have the skills, training, or expertise to do so. This meant care records were not always fit for the purpose of meeting people's care and health related needs.
- Systems to record incidents and concerns relating to people's health were not always used. This had not

been identified by the provider before our inspection and meant the provider had not ensured the regulated activity of treatment of disease, disorder or injury was always effectively overseen by an appropriately qualified person.
● We reviewed agency staff profiles and observed there was no evidence 2 regular agency staff had completed any training relating to their roles. This meant the provider's systems to ensure agency staff had received appropriate training were not established or always operated effectively. This increased the risk of people being supported by agency staff who did not have the skills to meet their needs.

The provider had failed to implement and operate effective systems to ensure the quality and safety of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider did not always submit statutory notifications to CQC for allegations of abuse. Statutory notifications give CQC important information, including what the provider has done in relation to concerns and can help inform us of when we will next inspect a service.
● At the time of our inspection, there was not a registered manager in post. The manager told us due to not feeling well supported by the provider, "There has been times where I have sat here and don't want to have my registration." Not having a registered manager in post increases the risk of the minimum standards of care people should receive not being achieved.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Although some people's care plans and risk assessments had not been reviewed or fully completed due to their more complex health related needs, we found other people's care plans were person-centred and contained information about who people were and what was important to them.
● On our first day of inspection, we observed a staff member quickly make arrangements to go and visit a person and their relative following an increase in falls. The staff member and the manager understood how important it was for this person to remain supported in their own home and wanted to do everything possible to support this.

Working in partnership with others
● The manager was frustrated with the provider not being present for meetings where their presence was required. For example, the manager told us a meeting with a commissioner had been rescheduled 5 or 6 times by the provider due to being too busy or having another more important meeting. This meant the manager did not always have the support they needed from the provider to discuss service development with external professionals.
● We found evidence of partnership working with external health professionals to promote people's needs being met. For example, the management team recently supported a person to move to a new home to improve their safety and liaised extensively with the local authority to do so. The person's relative told us, "I feel they have gone above and beyond sorting things out for me."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The management team had good systems in place to engage with staff. The manager had arranged team meetings, but due to this being difficult for staff to attend due to their personal commitments and attending care calls, they also arranged more frequent 1:1 meetings with staff. Newsletters were also sent to staff to keep them informed of important changes.
● Regular surveys were carried out with people receiving support. We saw the manager had acted on

feedback people gave. For example, 1 person wanted staff to support them with their shopping and this was actioned.

● Staff and relatives felt the manager was approachable. For example, 1 relative told us, "Current manager used to be a carer and is lovely. [Manager] still calls in occasionally, can always get hold of them on by phone and know they will listen to you."

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 provider's policy promoted their legal responsibility to act on the duty of candour.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems and processes did not ensure people always received safe care and treatment. The provider had failed to always mitigate risks relating to people's medicines, health and safety. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement and operate effective systems to ensure the quality and safety of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We imposed conditions on the provider's registration.