Niche Care Limited

# Niche Care Kirklees

## Inspection report

Headrow House
19 Old Leeds Road
Huddersfield
HD1 1SG

Tel: 01484794144
Website: www.nichecare.co.uk

Date of inspection visit:
18 February 2021
12 March 2021

Date of publication:
02 June 2021

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

About the service
Niche Care Kirklees is a domiciliary care provider based in Huddersfield, and provides personal care to adults and older people in their own homes. At the time of our inspection the service supported 41 people. Not everyone who used the service received personal care. 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.

People's experience of using this service and what we found
People's visit times were not always reliable or consistent. Staff were not allocated enough time to travel between visits and this meant visits were often too late for people's care and support needs to be met properly.

There were enough staff, although they were not deployed effectively to enable people's visits to be on time. Recruitment procedures were not robustly followed, which meant staff had not always been safely checked to ensure they were suitable to care for people.

People were not always supported to receive their medicines when they needed them and recording of medicines was not robust.

People and relatives gave positive feedback overall about staff who delivered the care, although they were not all assured the management of the service was good enough.

Care plans were not accurate as some individual risks were not identified or mitigated. There was a lack of person-centred care and people were not always supported in line with their needs.

There were weaknesses in the leadership and management of the service. There was a registered manager who was working alongside a new manager to enable them to take over the day to day running of the service.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

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

Rating at last inspection
This service was registered with us on 3 August 2020 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about people's calls being late or missed, people receiving unsafe care and a lack of effective management of the service. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the all sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to people receiving appropriate, safe and reliable care, safe recruitment procedures and weaknesses in the management of the service, at this inspection.

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 request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

| | |
|---|---|
| **Is the service safe?**<br>The service was not safe.<br>Details are in our safe findings below. | **Inadequate** |
| **Is the service effective?**<br>The service was not always effective.<br>Details are in our effective findings below. | **Requires Improvement** |
| **Is the service caring?**<br>The service was not always caring.<br>Details are in our caring findings below. | **Requires Improvement** |
| **Is the service responsive?**<br>The service was not always responsive.<br>Details are in our responsive findings below. | **Requires Improvement** |
| **Is the service well-led?**<br>The service was not always well led.<br>Details are in our well led findings below. | **Requires Improvement** |

# Niche Care Kirklees

**Detailed findings**

## Background to this inspection

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

Inspection team
The inspection was carried out by one inspector and two Experts by Experience. 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 in line with the requirements of the provider's registration. A new manager had been recruited and they were in the process of registering with CQC. When registered, this means they are legally responsible for how the service is run and for the quality and safety of the care provided with the Care Quality Commission.

Notice of inspection
The inspection was unannounced. Inspection activity started on 16 February 2021 and finished on 16 March 2021. We visited the office location on 18 February 2021.

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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection

During the inspection
We spoke by telephone with 11 people who used the service and eight relatives about their experience of the care provided. We spoke with five staff by telephone. We spoke with the registered manager, and the manager during the site visit. We reviewed a range of records. This included two people's care records. We looked at three staff files in relation to recruitment and training.

After the inspection
We requested information sent by email and continued to seek clarification from the provider to validate evidence found.

Inadequate

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● Risks to people's safety were not sufficiently identified, mitigated or monitored. People's individual risk assessments did not give enough information for staff how to care for people safely. For example, one person had a significant health condition, but there was no other information for staff to be aware of signs of concern or how to support them with this. The person's mobility was recorded as being affected by their health, but no further information to guide staff to support them safely.

● One person's care records showed they had a bed rail, but there was no assessment of risk, or recognition of lessons to be learned, even though there had been a safety incident with this equipment. This person's records showed they needed thickener in their drinks, but there were no directions for staff and no reference to thickener in the diet/drinks risk assessment.

● People and their relatives gave us mixed feedback about the safe delivery of care. One person said, "I do feel safe with the carers. They are very kind and patient with me." Another person said, "To a certain extent I feel safe. These [carers] aren't patient enough, they tried to rush me." Where people did not feel safe, they said this was largely due to care times being variable and not always reliable.

Using medicines safely

● Medicines were not always managed safely. There were gaps in the recording of some people's medicines and some conflicting or missing information in care plans. For example, there were different doses recorded for one person's medication in their care plan. Where one person needed cream applying to their skin, the information for staff was not clear on where or how to apply.

● We received mixed views from people and their relatives about the support given for medicines. One relative said, "Staff give [person] tablets three times a day, and watch them take them. There have been times when [person] hasn't been given their medicine and I have spoken to [staff] about it." One person said, "They help me with my medicine, but sometimes I have to remind them."

●There was a risk people's medicines would not be given when needed where care visit times were inconsistent or recording was not clear.

● Audits of medicines were carried out, but not robust enough to consistently identify actions to be taken. For example, one person's medicine records showed medicine had been missed, but there was no evidence action had been taken.

We found no evidence people had been harmed. However, systems were not in place to demonstrate safety was effectively managed. This placed people at risk of harm. 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

● The provider was not able to evidence all staff had been robustly recruited. There was missing information in two of the staff files we reviewed and the provider was not able to show all checks completed satisfactorily before they cared for people. The provider agreed to review their recruitment files immediately.

Systems were not in place to demonstrate staff were safely recruited. This placed people at risk of harm. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were sufficient numbers of staff to carry out people's care, but they were not deployed effectively to provide consistency for people. Travel time was not planned accurately on the staff rotas, which meant staff were sometimes rushing between calls and not always arriving when people expected them.
● People and their relatives felt where there was a lack of consistency of care staff and visit times, care needs had not been met.
● Some people and relatives told us visits had been missed. One person said, "I have had to call [the office] quite often when the carers don't turn up. The company is always apologetic and get someone out to me quite quickly." Another person said, I have had to phone the company when the carer hasn't shown up. It is not every day but it is important to me that they come. The company got someone out to me pretty quickly thankfully."
● The registered manager told us they were in the process of improving their monitoring systems in light of recent concerns about missed and late calls and there was an action plan in progress.

Systems and processes to safeguard people from the risk of abuse
● Staff felt they had sufficient training to identify safeguarding concerns and the procedures to follow if they were worried about possible abuse. The registered manager responded immediately to safeguarding concerns which arose from our conversation with one person.
● People and their relatives felt the lack of consistency of care staff and visit times meant care needs had sometimes been neglected. For example, one relative told us their [person] had missed visits, often during the weekend, which meant they were left without hot drinks all day and sometimes they were unable to reach their snacks or be supported with their medicine.
● The registered manager told us they were in the process of improving their monitoring systems in light of recent concerns about missed and late calls and there was an action plan in progress.

Learning lessons when things go wrong
● Systems and process were not sufficiently robust to ensure learning from incidents. For example, recorded within a written compliment from a relative, was also information of concern about the quality of care. This had not been addressed.
● Where the local authority had raised actions for the provider to take following contract visits, these had not always been rectified quickly.
● There was limited evidence of learning from complaints raised about the service. Where some people and their relatives had complained, the same issues were repeated.

Preventing and controlling infection
● We were assured that the provider was effectively ensuring the prevention and control of infection. Supplies of PPE were available to all care staff and staff were regularly reminded of its correct and safe use. Regular staff testing was carried out.
● People said staff wore PPE when carrying out their care tasks. One person said, "Staff always wear gloves and aprons and they always wash their hands."

● Staff training included infection prevention and control, and staff confirmed they understood safe practice for preventing the spread of infection, in line with government guidelines.

Requires Improvement

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.
This is the first inspection for this newly registered service. This key question has been rated Requires Improvement This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Assessments of people's needs lacked consistency and information. Care plans were not always clear; at times they were written in both the first and the third person. Information, such as equipment and support was sometimes conflicting. For example, one person's record showed they needed no support with the toilet in one section, yet referred to them requiring staff support for using the commode in another section.
● People's choices and agreed times of care were not always reflected in the delivery of care. For example, one person's care plan said their support time was 9am, yet records showed staff attended the call around two hours later. The 9.30pm call was attended after 11pm. One person told us their first morning call was too late to meet their needs as carer staff could be as late as 11am. Another person said, "The times could be better, that is the real issue. They came at 7.05 the other day which is far too early. 9am would be better."
● Staff told us they did not have time to read people's care plans and sometimes the information available lacked detail. This meant they did not always understand people's care needs or assessments of risk before providing support.

Staff support: induction, training, skills and experience
● Staff said they had received sufficient induction and shadowing opportunities before they worked unsupervised and they felt prepared for their role.
● Staff told us they had enough training to enable them to care for people appropriately. Due to the COVID-19 restrictions staff had not always had opportunities for face to face training, such as in moving and handling people.
● The provider's training records showed much training was completed online and some staff had completed practical training where possible. The registered manager told us they maintained an overview of staff training and completed observational checks to ensure staff were competent.
● Staff said their training allowed opportunities for them to ask questions and they were confident if they needed further training this would be available. Staff and records confirmed spot checks were carried out by managers at regular intervals.
● We had mixed information from people and their relatives about whether they felt staff had the skills to care for them safely. One person said, "I think staff are well trained. They know exactly what to do; simple things like steeping my dentures, made such a difference to me." One relative said, "Some are good and some are not."

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● Not all people had support for meals, but where they needed this we received mixed views about how this was done. Some people felt supported in line with their needs. Where people did not feel as supported, they said this was largely because of the lack of consistent care staff and visit times. One relative told us, "There is such an inconsistency with the carers never being the same." Another relative said their relative did not have consistent support for a dietary supplement drink they needed.
● Care records included information about people's nutritional needs where they needed support from the service.
● Where there was a lack of continuity of care staff, this gave rise to risks going unnoticed and unreported. For example, one person's daily records showed they had repeatedly refused food, drinks and personal hygiene care for a period of two weeks. In that time they had been cared for by 13 different care staff and there was no evidence the person's care had been reviewed or consideration had been made to refer other healthcare professionals. The provider was in the process of reviewing this information at the time of the inspection.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

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
● People had signed their consent to care and treatment in their care records.
● There were processes in place for mental capacity assessments and best interest decision making, although where people had a designated power of attorney this was not consistently recorded.
● Staff we spoke with had some understanding of the MCA and told us about they understood the importance of gaining consent from people before carrying out care.

Requires Improvement

# Is the service caring?

## Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant people did not always feel supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People did not always receive support from a consistent staff team and there was a lack of detail in care records, which meant we were not assured staff knew people well enough to respect their wishes or provide person-centred care.
- Staff had a caring attitude to their work, although some staff told us they did not like feeling rushed because it meant they had little time to spend with people getting to know their individual needs and preferences.
- We had mixed views from people and relatives, many of whom found the care staff to be kind and supportive. One person said, "Oh yes, staff are kind to me and we have a bit of a laugh." Another person said, "Most of the carers are lovely. Some of the carers have been frazzled sometimes." Another person said, "[My carer] is more of a friend than a carer. I think we have a great friendship and I have complete trust in her."
- Some people found the service was not caring enough. One person said, "[One carer] just wanted to sit and use their phone" and another person said, "They don't tell me when carers are running late." One relative told us care staff were 'just going through the motions' rather than being caring and attentive. Another relative said their [person] could not build a relationship with carers 'due to them changing so much'.

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- There was mixed information about whether people's views were regarded. Where people felt their views were not fully considered, this was due to inconsistent care delivery times.
- People said staff involved them in making everyday choices and decisions. One person said, "Staff always ask me what I want and how I need it to be done. They don't just get on with it without asking me first."
- Most people told us staff respected their privacy and dignity. One person said staff ensured they used the bathroom in private and were discreet when providing personal care. Another person said they had expressed a view not to have a male carer for personal care, and staff respected this. One person said staff did not always close the curtains when supporting them with personal care. They said, "But people would really have to look in the window to see what I was doing."
- Some people said staff enabled them to do things for themselves as much as possible but were supportive when they needed extra help.

Requires Improvement

# Is the service responsive?

## Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Call times for some people were not consistent or in keeping with people's needs and preferences, which meant the quality of people's experience was variable. Some people reported care being met to their liking, whilst other people had a contrasting view. The provider was actively working to improve this and some people had noticed recent improvement. One relative said a recent request to alter the care provided had been actioned quickly.
- The provider was aware of some improvements needed to ensure care plans were detailed and accurate and there was work in progress to address this.
- Not all people we spoke with knew about their care plan but said they discussed their care requirements over the telephone so the company knew what care was required. Staff told us they did not always know what care people needed because they had not always read their care plan before delivering care.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Information in people's care plans was not always detailed enough to ensure staff understood people's communication needs. Staff told us where they knew people well, they understood their communication needs through caring for them.
- The provider was aware of their responsibility to ensure information was accessible to people in ways they could understand, should this be needed.

Improving care quality in response to complaints or concerns

- There was a complaints process in place and we saw the provider had made responses to matters that had been raised, although there were some missed opportunities to identify where quality could be improved.
- Some people were satisfied with how any concerns were dealt with if they had raised any. People and relatives knew the process to follow to raise concerns. However, some relatives did not feel complaints were sufficiently acknowledged or responded to, because they had raised concerns repeatedly with little improvement.
- People and relatives expressed frustration at not being heard or listened to. One relative said it was difficult to get through to the office on the telephone and some people confirmed their calls to the office were unanswered at times.

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

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant the leadership and management of the service was not robust or consistent enough to 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

- Quality audits were in place but had not addressed shortfalls in the quality of the care delivery as highlighted through the inspection process.
- Where audits had been completed, these did not always identify areas to improve. For example, care plan audits stated information was correct and accurate, when there was conflicting and missing information. Where actions were identified as a result of audits, it was not consistently clear what was addressed, who was responsible or when action was taken.
- People, relatives and staff gave us contrasting views about how well the service was managed. One person said, "I think it is well managed. I've had no problems and it all works smoothly." Some people told us they knew who the manager was and they felt the service was making improvement. One person said, "With [manager's name] in place now, it is well managed. Where people and their relatives did not think the service was run well, this was largely due to communication being ineffective and a lack of consistent care.

Systems were not operated effectively to consistently assess, monitor and improve the quality and safety of the services provided. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider was working towards an action plan, which showed they were aware of the issues of concern and taking steps to make improvements. Changes to the management were being implemented so responsibilities would be more clearly defined.

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

- On the whole staff reported feeling able to approach managers and said there was a positive workplace culture. Some staff felt they were able to ensure people had individualised support if their rota was consistent.
- Feedback from people, relatives and staff highlighted concerns around care being task-focused rather than person-centred. People gave contrasting information about the provider's ability to deliver care which put their needs first.

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

characteristics; Working in partnership with others

● People, relatives gave varied feedback about their engagement with the service; some reported a lack of partnership working, whilst others were more complimentary.

● Staff said internal communication, such as staff meetings, helped them to feel informed and involved. They were confident improvements at the service were being made.

● There had been some meetings with the local authority commissioning team to address shortfalls in people's care and support, and the provider was working closely with them to try to improve the service.

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<br><br>The provider had failed to ensure people's safe care and treatment. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>There were weaknesses in the quality of the service which impacted on the delivery of safe, effective and reliable care for people. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>Recruitment procedures were not robustly followed. |