Niche Care 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

About the service
Niche Care is a domiciliary care agency providing personal care to adults living in their own homes. 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. At the time of the inspection, the service was supporting around 300 people.

People's experience of using this service and what we found
We found concerns relating to governance within the service. Although there were comprehensive systems in place to enable managers to monitor the service, we saw many examples of poor quality and at times unsafe care. Management records showed there was an awareness of late calls, short calls and missed calls, but people told us these were still happening; care records reflected this.

Managers had failed to take appropriate action when concerns were identified. They had not reported certain key incidents to the Care Quality Commission, which is a legal requirement. They had also failed to report a breach of confidential personal information to the Information Commissioner's Office. The registered manager addressed this after we brought it to their attention.

We have made a recommendation that the registered person has robust oversight of complaints and concerns, so that any allegations of abuse are identified and reported in accordance with the law.

We were not assured people were being cared for safely. Care visits did not always take place at the agreed time or for the agreed duration. This meant people were at risk of harm where, for example, their medication was not administered at the correct time, or they had to wait a long time before being taken to the toilet or given a drink.

People using the service and their relatives gave us a mixed picture about their experience of Niche Care. Some praised the service, with one person telling us: "The care package is reviewed regularly and there is an annual review where [we] have the opportunity to discuss. The mobile app is really effective where we can monitor regularly. Everything is listed including medicines, visits done, timings etc." Another person said: "[my relative] gets on well with her regular carers. They are brilliant." However, some people commented far more negatively, raising concerns about late and missed calls and staff not having the knowledge they required. We reported one matter to the local authority safeguarding team.

Staff also gave us a mixed picture of Niche Care. Some were very positive about their employer, saying they felt well supported and would recommend them to anyone seeking care, but others were not of this view, and described the company as disorganised, citing examples of late rotas and last minute changes, alongside poor levels of support.

Recruitment was undertaken safely, with appropriate background checks before staff started work, and staff

received training in relevant areas relating to care and safety.

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 (published March 2019)

Why we inspected
The inspection was prompted due to concerns received about how the provider was ensuring care was delivered safely in a way that met people's needs, and about the provider's governance arrangements. A decision was made for us to inspect and examine those risks. As this was a focussed inspection, we reviewed the key questions of safe and well led only. Ratings from previous comprehensive inspections for other key questions were used in calculating the overall rating at this inspection. The overall rating for the service is now requires improvement.

We have found evidence that the provider needs to make improvement. 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.

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?

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.

Niche Care Ltd

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.

Inspection team
This inspection was conducted by two inspectors and an Expert by Experience; 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. 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
We gave the service short notice of the inspection. This was because we needed to be sure the inspection could be inspected safely during the ongoing COVID-19 pandemic.

What we did before the inspection
Before the inspection, we reviewed all the information we held about the service including information about important events which the service is required to tell us about by law. We requested feedback from other stakeholders. These included two local authorities who commissioned services from the provider, and the local safeguarding team. We also looked at concerns people using the service or their representatives had raised with CQC prior to the inspection.

We used all of this information to plan our inspection.

During the inspection
Inspection activity commenced on 1 February and finished on 9 February. We visited the service on 5 February 2021.

We spoke with eight people using the service and five people's relatives. We also gathered information from eight members of staff including care workers and the registered manager.

We looked at care records for 11 people using the service We looked at training and recruitment records for staff. We also reviewed various policies and procedures and the quality assurance and monitoring systems of the service. As part of the inspection, we referred information of concern to the local authority's local safeguarding team and contracts team.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

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 the last inspection this key question was rated as good. At this inspection this key question has deteriorated 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

- Most people using the service told us they felt safe when receiving care, and told us they had not had any concerns in this respect. However, some relatives told us they had raised considerable concerns regarding neglect, where care staff had not attended care calls, putting people at risk of harm. One relative told us they were at their "wit's end" and said one care call was so poorly carried out their relative was left "sobbing." CQC have reported this incident to the local safeguarding authority. Another relative said: "I question whether [my relative] is safe because the carers left her in her chair two nights instead of putting her to bed." They went on to say their relative had suffered a negative health consequence following this.
- Some staff did not always know the procedures for reporting any concerns. One said they thought they would report concerns to managers, but did not know who any managers within the service were. Other staff were more knowledgeable about safeguarding.
- The provider's complaints log showed several incidents where there were allegations of abuse. The provider had not notified CQC or the local authority of these incidents, which they are legally required to do.

We have made a recommendation that the registered person has robust oversight of complaints and concerns, so that any allegations of abuse are identified and reported in accordance with the law.

Learning lessons when things go wrong

- Records we were provided with indicated there had been several serious complaints in recent months. There was no information available about any lessons learned from this. For example, one complaint was received four months prior to the inspection and related to staff not staying for the duration of their care calls; we saw this was still a significant issue at the time of the inspection, meaning the provider had not learned lessons or implemented effective improvements in this area.
- One relative told us they had to frequently raise the same issue, but said it was never adequately resolved or addressed. At the time of the inspection they told us they were still waiting for a response from the provider regarding their concerns.

Governance arrangements within the service were not adequate to ensure safe, good quality care was being delivered. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risks, such as choking, moving and handling and infection control, were identified during the initial assessment of a person's needs, but some staff told us they did not have the time to read these. One staff member described how specific information relating to risk was available on the rota app on their phones,

but said sometimes changes were made at very short notice which meant they weren't aware of risks when they undertook some care calls.
● Moving and handling risk assessments in people's care plans had not always been completed in sufficient detail to ensure care was carried out safely. For example, where people required hoisting there was not always enough information for staff to know how this should be done. One relative told us about an incident where staff had not undertaken moving and handling tasks safely, leaving their relative in pain.
● Some people had been assessed as requiring two staff to ensure their mobility needs could be safely met. However, care records showed the second staff member had attended for only a very short amount of time. It was unclear how the person's mobility needs had been safely met in such a short period of time.
● One staff member described how they were assigned to provide care to a person they had not been briefed about, and arrived to find they did not know how to safely provide care due to a specific piece of equipment they had not received any training for.

Risks were not effectively identified, assessed or monitored within the service, putting 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.

Preventing and controlling infection
● Staff told us they had received training in infection control, and the provider's training records confirmed this.
● An infection control audit had been undertaken, with actions arising from it logged and addressed.
● Personal protective equipment (PPE) was available for staff to use and staff confirmed it was plentiful. When managers carried out spot checks of care visits, the use of PPE was monitored to ensure care was provided safely.
● One person's relative raised concerns about staff not using PPE correctly, and the provider therefore arranged to meet with the staff concerned to remind them of their responsibilities.
● Staff told us they had access to regular testing for COVID-19 during the ongoing pandemic.

Using medicines safely
● Medicines were predominantly managed safely, although there was a risk that the required gaps between medication doses were not always observed due to considerable changes in visit times. One person's relative said: "They keep changing their times. One day they come at 7am the next it might be 9am. That means that [my relative] doesn't get his meds on time and I have to do it."
● Staff told us they had received medication training and records confirmed this. One relative told us about an incident where they felt the staff member did not understand their relative's medication. However, they contacted the provider and asked that this staff member did not attend again, and the provider took appropriate action.
● Records of medication were clear, and the provider regularly audited these.

Staffing and recruitment
● Staff were safely recruited.
● We looked at six staff files and found appropriate background checks had been undertaken. This included Disclosure and Barring Service (DBS) checks.
● Where staff had previously worked with vulnerable adults their reason for leaving had been identified.
● Staff told us they received a suitable induction and with a few exceptions staff told us they felt they had sufficient training to do their job. One person's relative said: "They are very well trained and effective at all their care duties."

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 the last inspection this key question was rated good. At this inspection it has deteriorated 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

- Governance arrangements within the service were comprehensive but had failed to address significant shortfalls in the quality of care delivery and regulatory compliance.
- Many of the care records we looked at showed staff were not staying for the full duration of the visit. In some cases there were instructions to staff to ensure they did not cut visits short but these instructions had not been complied with. Some of the care plans we looked at emphasised the importance of staff using any extra time available when the care tasks were completed to provide social engagement and stimulation to the person but this did not happen The provider's governance arrangements had not been sufficient to identify and address this.
- People gave us a mixed picture of their view of quality performance within the service. Some said they were happy with the management of their service, while others were more negative. One person said: "I don't think they are well managed, they don't listen," whereas another said: "I think the service is well managed. Sometimes it is difficult to get hold of [out of office hours] but generally they respond quickly and reply promptly to e-mails. I can usually speak to the manager or a supervisor, no problem."
- Staff also gave us a mixed picture about the service and management support, with one describing the management as "great" but others telling us they didn't get the support they needed, particularly out of office hours.

Governance arrangements within the service were not adequate to ensure safe, good quality care was being delivered. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Most people we spoke with told us their care met their needs and said they were enabled to achieve the outcomes they wanted. One person said: "They are brilliant." Some people, however, told us this wasn't the case, with one saying: "I am not always happy with them because they do not listen. I do have some complaints, if I ring the office they still won't listen. I suppose they are doing their best, but I get so tired and don't feel supported to care for [my relative]"
- Staff gave us a mixed picture of their experience of working at Niche Care. One said: "There's not enough information from the office, we don't know what's going on, I don't even know who is in charge there."

Another described the systems for allocating care visits as "chaotic." However, some staff contradicted this and told us they were happy with Niche Care as an employer, with one describing them as "really supportive."

● When things did go wrong, relatives told us they didn't always get a response which was satisfactory. Some of the complaints we looked at had not been fully addressed, and one relative told us they felt ignored by the provider.

● We looked at records of complaints the provider had received. Some of these represented allegations of abuse. However, the provider had failed to recognise this and had therefore not submitted notifications to CQC, which they are legally required to do.

● One complaint we saw involved a serious data breach, where a person's family had accidentally been given a large amount of a staff member's personal information, including financial records. The provider's investigation into this incident showed they did not alert the staff member concerned, nor did they report themselves to the Information Commissioner's Office. Following the inspection the registered manager told us this would be addressed, and they would source training to ensure staff's knowledge was improved in this area.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others.

● The provider had a system in place to obtain feedback from people using the service, their relatives, and care staff. We saw this was predominantly positive.

● Some staff told us they didn't feel engaged with the provider, and some said they would be "scared" to make suggestions for improvements. However, others told us they felt the provider communicated well with them.

● People and their relatives told us Niche Care staff worked in partnership with other agencies, with one telling us about Niche staff making a referral to a healthcare practitioner for them. Another person told us: "I did have a complaint one time. [My relative] had got a cut…which wasn't healing. I rang the office and they responded quickly by contacting the GP for a District Nurse to come out. "

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 Risks were not effectively identified, assessed or monitored within the service, putting people at risk of harm. Regulation 12 (1)(2)(a)(b)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance arrangements within the service were not adequate to ensure safe, good quality care was being delivered. Regulation 17 (1)(2)(a)(b)