Better Healthcare Services Plc

Better Healthcare Services (Luton)

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?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Better Healthcare Services (Luton) is a domiciliary care service. The service provides personal care to people living in their own homes. At the time of the inspection, the service provided support to 158 people, of which 142 were in receipt of personal care.

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 were not always safe and were left without care at the time they required it due to the large number of missed and late care visits.

People had risk assessments in place. However, these had not been consistently reviewed and did not provide staff with relevant information to keep people safe.

Medicines were not always administered to people at the times prescribed. The many missed and late care visits meant that medicines were not being managed safely. One person told us, "Sometimes the timings of calls mean that medicines are not regularly spaced out between doses." Audits were inconsistent and there was minimal information available of actions which had been taken to address areas of concern.

The quality assurance processes were not robust and did not drive improvements in the service. There was a lack of management oversight and leadership within the service.

The provider had an infection control policy in place which had been updated to include information relating to COVID-19. Staff were provided with an adequate supply of face masks, gloves and aprons.

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 11 December 2019).

Why we inspected
We received concerns in relation to missed and late care visits, the management of medicines and the leadership of the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those

key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at 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.

We asked the provider how they intended to improve following our visit to the service. They provided enough information to assure us they would take action in response to our most urgent concerns.

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 Better Healthcare Services (Luton) on our website at www.cqc.org.uk.

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 two breaches of the Health and Social Care Act 2008 in relation to safe care and treatment and good governance of the service at this inspection.

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?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Better Healthcare Services (Luton)

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 undertaken by one inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes.

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 announced. We gave the service 72 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 25 January 2021 and ended on 01 February 2021. We visited the office location on 25 January 2021.

What we did before the inspection
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 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 looked at all the information we hold about the service including notifications. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service and seven relatives about their experience of the care provided. We spoke with 10 members of staff including the director of homecare, operations director, operational support manager, senior care workers, care workers 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 four people's care records and two medication records. We looked at four staff files in relation to recruitment, training and staff supervision. We looked at training data and quality assurance records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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 now deteriorated to required 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.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of harm and abuse; Using medicines safely; Learning lessons when things go wrong

- Risk assessments did not always identify risks or contained contradictory information meaning they did not reduce the risks and people were not safe. For example, there was no information recorded to identify risks relating to continence care. For another person their medication risk assessment stated they required staff to remind them to take their medicines and later it stated for staff to administer medicines.
- Care plans and risk assessments had not been consistently reviewed and updated to reflect people's current needs. This meant information was not available to inform the staff on how to provide appropriate care and support.
- Care plans contained information regarding medical conditions. For example, for people who had a stroke, diabetes and Alzheimer's disease, however, these did not detail the specific care and support needs for people living with these or other medical conditions.
- The electronic call monitoring system identified people were in receipt of late or missed care visits. People and relatives' comments included, "We have called the office at night when the care visit has been over an hour late." Another person told us, "At weekends the night call is late and staffing is not so consistent." This meant they did not consistently receive the care which they required to keep them safe. Scheduling of agreed care visit times did not allow staff sufficient time to complete care and support.
- A staff induction process was in place and included a range of training and shadowing, followed by a senior staff member checking staffs understanding and skills (competency checks). Records of competency checks viewed contained comments including, 'no hoist used'. There were no further checks to demonstrate the staff were competent and safe to use moving and handling equipment. People and relatives' comments included, "Sometimes the company don't provide a lot of training, two days and then staff are left to work alone." Another person told us, "One staff member arrived and didn't know how to complete basic care and my (relative) had to talk them through what to do."
- People did not always receive their medicines at the time which they were prescribed due to late or missed calls. This could impact on people's health or cause risk of harm to health.
- Medicine charts were not always completed properly. We saw gaps in the medicine administration records with no explanation provided. This meant people were put at risk due to poor staff practice.

We found no evidence that people had been harmed however, systems to assess and manage concerns, risks and medicines were not robust to keep people safe. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Despite concerns identified during the inspection in regards to risk management people told us they felt

safe.
● Staff had received safeguarding training and had an awareness of abuse.

Staffing and recruitment
● Relevant checks of new staff were not fully completed by the provider. Application forms did not always contain a history of education or full employment. Health declaration forms had been completed by staff but did not contain evidence of an evaluation to determine if a person was physically or mentally fit for work. This was discussed with the provider during the inspection who took immediate action to review the process.

Preventing and controlling infection
● Staff had received training about infection control, COVID-19 and the use of personal protective equipment (PPE).
● Staff told us they had access to adequate supplies of PPE at all times. People confirmed that staff demonstrated good infection control practice whilst providing their care and support.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The quality assurance processes in place were not effective in identifying the failings of the service. Trends identified through audits were not used to drive improvement and positive outcomes for people.
- Arrangements were not robust in monitoring the staff support or communication between office staff and care workers. Staff told us they had received few supervisions and spot checks of their ability to carry out their role safely and effectively. One staff member told us they had not received any supervision or spot checks since their induction over three months ago, another staff member stated they had received two supervisions since starting employment in 2019.
- The on-call communication process required review to ensure that it was effective. One staff member said, "Some of the communication from the office does not flow out to carers." And, "There is little acknowledgement from the office and management when carers email concerns."
- The registered manager had not undertaken refresher training to ensure their knowledge and skills remained up to date and relevant.
- Processes and systems did not identify where quality was compromised or any actions which had been taken to address concerns. Some of the information we viewed including care plans, risk assessments, daily notes and medication administration records which were either incorrect, incomplete or were overdue a review.

We found no evidence that people had been harmed however, systems were not robust enough to demonstrate management oversight and support continuous improvement of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- One person told us following them raising a complaint the management were prompt in resolving the issue and provided them with a written apology in a timely manner.
- Following the inspection the provider shared with us an action plan which they had implemented to address the failings and shortfalls of the service. Additional resources had been provided to the registered manager to support with the implementation of the action plan to ensure positive outcomes for people and

staff.

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

- People and relatives told us they had been involved in the assessment and care planning process.
- Staff spoken with informed us team meetings during the pandemic had been scheduled using video conferencing however they did not always receive the minutes of these.
- The provider informed us following the inspection they had sent a survey to staff to obtain their feedback. Information from this would be used to support in driving change and making improvements.

Working in partnership with others

- Records shared demonstrated the provider worked closely with the local authority, community nurses and other health care teams.

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
Nursing care Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: People who use services were put at risk due to the impact of late or missed calls. Care plans and risk assessments did not contain adequate information to enable staff to support people safely. There was a risk that peoples medicines may not be administered at the prescribed time which could impact on people's health and cause risk of harm to health. Regulation 12 (1) (2) (a) (b) (c) (g)

Regulated activity	Regulation
Nursing care Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: Systems in place were not robust in monitoring the quality of the service. Areas identified through audits had not been actioned to improve the service. Checks were not in place to ensure that staff members had the appropriate skills and experience to support people safely. Regulation 17 (1) (2) (a) (b) (c) (e)