

Niche Care Limited

Niche Care Wakefield

Inspection report

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Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Inadequate 

Is the service caring?

Requires Improvement 

Is the service responsive?

Inadequate 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service

Niche Care Wakefield is a domiciliary care provider based in Horbury, Wakefield and provides personal care to adults and older people in their own homes. At the time of our inspection the service supported 120 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 had unreliable visit times, which meant their care was not consistent. Calls to people were sometimes cut short and staff did not have enough time to travel to the next person. Visits were frequently late or sometimes missed. This impacted negatively on people's wellbeing and safety.

There were not enough staff to meet people's needs in a timely manner, and staff turnover was very high. Staff were not always safely recruited, inducted, trained or supervised, which put people at risk of harm.

People did not always receive their medicines when they needed them.

There was not always sufficient assurance infection prevention procedures were followed.

People and relatives felt care staff were kind and caring, although they had little confidence in the management of the service.

Care plans were not detailed or risks to individuals sufficiently identified. Care was not person centred or delivered in line with people's needs and preferences.

The service was not run safely or effectively. The provider failed to assess, identify and mitigate the risks involved in the delivery of care to people. This put people at risk of harm and poor care.

There was a new manager who was working alongside senior managers to prioritise aspects of the service in need of immediate improvement.

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.

This service was registered with us on 14 October 2019 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.

We met with the provider soon after the inspection and asked them to submit an action plan detailing what changes they will make to ensure people receive safe, reliable care. The provider has said they will stop taking any further care packages, until they can provide assurance about quality and safety.

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, staffing, the handling of complaints and weaknesses in the management of the service, at this inspection.

Follow up

We will request an updated action plan from 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 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 effective?

Inadequate ●

The service was not effective

Details are in our effective findings below

Is the service caring?

Requires Improvement ●

The service was not always caring

Details are in our caring findings below

Is the service responsive?

Inadequate ●

The service was not responsive

Details are in our responsive safe findings below

Is the service well-led?

Inadequate ●

The service was not well led

Details are in our well led

Niche Care Wakefield

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 two inspectors 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 did not have a manager registered with the Care Quality Commission in line with the requirements of the provider's registration. Since the service was registered there had been two registered managers previously in place but they were no longer in post. 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 20 January 2021 and finished on 2 February 2021. We visited the office location on 20 January 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 10 people who used the service and 11 relatives about their experience of the care provided. We spoke with 12 staff by telephone. We spoke with the manager, and the operations manager during the site visit. We reviewed a range of records, this included four 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. We asked the provider to urgently meet with us to gain assurances about actions they would take to ensure people received safe care.

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 Learning when things go wrong

- Risks to people's safety were not adequately identified, mitigated or monitored.

Individual risk assessments for people were not in place to guide staff how to care for people safely. Staff did not know how to care for people because there was little information recorded in their care plans. For example, some staff told us the only thing they knew about some people was their name and address, but not their care and support needs. One member of staff said they had tried without success to contact on-call managers for a person's home address. but there was no reply and a member of public helped them find the right address.

- Staff had not received adequate safety related training where people had specific risks and care needs, such as for moving and handling, medicines or equipment. Some people relied on medical devices, such as a catheter to empty their bladder, a feeding tube for food, drink and medicine, and equipment, such as a hoist for moving and handling. However, some staff said they had not done any training or been shown how to support people with these, or knew the risks involved. One member of staff said, "I had no idea what I was doing. I told managers and they just said I would be fine. I had to ask the [person] what to do and they helped me."

- People gave us mixed feedback; some people felt safe being cared for, whilst others did not. One person said, "I feel really safe with them" and another person said, "Yes, everything is safe. They lock the door." However, one relative told us, "I've had one of them lose the front door key. One of them left the front door open and [person] is bed bound. One time the gas was left on".

Systems were not in place to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning when things go wrong

- People were not sufficiently safeguarded and there was little learning identified when things went wrong.
- Staff did not all know the procedures to follow to ensure concerns were reported appropriately. Incidents were not always reported or referred to the local authority safeguarding teams as required and there was ineffectual management oversight of people's care and support. For example, we reviewed one incident where a person had been left without appropriate care and had fallen from a commode, yet this had not been reviewed, reported or investigated by the provider.
- People's care needs were neglected because they did not receive their calls on time. If people needed support with food, drink, continence or medication, they sometimes had to wait until staff arrived and so went without support if staff were late or did not turn up at all. The time spent caring for people was sometimes cut short because care staff were rushing from one person's address to another. This meant staff

did not complete the full range of tasks people needed support with. There had been repeated complaints reported to management about missed and late calls, but with insufficient action taken to prevent this from happening again.

- People were not happy with the unreliable service. One person said, "Every day you have to phone them [office] and say where's my carer." Another person said, "They [carers] are coming at any time, missing me, and I'm having to call them, and they have come at 11 o'clock at night. I can have eight different carers." One relative told us, "The agency forgot to put [my family member] on a call on Christmas eve, so no one came all day."

Safeguarding procedures were not followed to ensure people were safe from the risk of abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- Recruitment procedures were not robust and staffing levels were not adequate to meet people's needs.
- There was missing information in staff files and the provider was not able to evidence staff had been robustly selected, vetted or their competence checked before they worked unsupervised in their role.
- A large number of staff told us they did not all feel prepared or confident to carry out the tasks required and some relied on the people they supported telling them how to provide the care. One member of staff said, "I was just sent straight out, I was new to care and I didn't know what to do." Another member of staff told us they had observed a colleague once before working unsupervised, but said their colleague was also very new to the role. One member of staff told us they had been given a brief introduction to the company, but had not been given any instruction about what to do and no one checked if they were capable. They said, "I was just left to get on with it."

Robust recruitment procedures were not followed to ensure staff were suitable to work with vulnerable people, which 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 had been a very high staff turnover and the provider told us they were still recruiting for new staff. Staff overwhelmingly told us there were not enough staff and this meant they were rushing to complete care calls. Travel time was not sufficiently factored into staff rotas, which meant staff were travelling in time allocated for care.
- People and relatives told us there were not enough staff, and staff lacked skills and experience. One relative said, "They need more experienced staff. Those that know how to deal with catheters etc. The continuing care is not very good." Another relative said, "Once, two [staff] came and they said they weren't hoist trained so we couldn't get [person] out of bed."

There were insufficient staff to meet people's needs and staff did not have sufficient induction, training or support. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Using medicines safely

- People did not always receive their medicines safely and on time.
- One person required a four hour interval between medicines, but their calls were not arranged to ensure this happened and this resulted in missed medicines or doses given too close together. Another person did not receive their morning call until early afternoon, meaning their morning medicine was significantly delayed.

- Staff had not received sufficient training to know how to support people safely; training was through computer based learning and there were no practical demonstrations or assessments to check staff understanding.
- Records of medicines were inconsistent, poor or sometimes non-existent. Some staff said they had repeatedly reported a lack of paperwork available for them to complete, but management had not taken any action to address this. A member of staff said records were completed to show one person had been supported with medicines, yet the medicines were still in their container. Another member of staff said there were inconsistencies in the recording of the weekday one person needed their pain relief patch.
- We received mixed views from people about the support they received for medicines. One person said, "They watch me take my medicine out of the blister packs. They help me if I need it." A relative told us, "They are quite happy to give the medication. I put it out in one of the weekly dispenser boxes. They always write it down what they have given [person]. No problems, whatsoever." However, one person said, "One of them gave night time tablets during the day two weeks ago. They missed the day and morning tablets even though everything is in a dossett box." One relative told us their family member regularly had received their breakfast medicines in the afternoon and had sometimes missed doses altogether.
- We discussed unsafe medication practices with the provider and requested the provider carry out an immediate review of people's medicines to ensure these were being given safely, in line with good practice guidelines; the provider agreed to complete this and sent confirmation of action taken.

There were no systems in place to ensure the proper and safe management of medicines. 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

- There were weaknesses in the systems for assuring the prevention of infection.
- There were supplies of PPE stored in the office and the manager told us staff were reminded to use this effectively and safely. Some care staff expressed concern about the quality of the PPE and reported gloves tearing. One member of staff did not feel their PPE provided enough protection when managing people's care needs.
- People and relatives told us staff wore PPE, and said "Mask, pinny and gloves. Yes, they change if they need to." One person said the staff wore PPE which was not effective, "Gloves with holes in them, so they split. That happened last night. [The carer's] fingers went through when she was helping me."
- The provider did not have a consistent or reliable system for ensuring training and spot checks of staff practice, such as wearing PPE. Some staff could recall having been shown how to put on and remove PPE safely, but other staff said they learned by watching colleagues. We discussed feedback from the inspection with the provider in relation to ensuring staff training and competence. The manager told us spot checks of practice for all staff were being immediately implemented as part of the new management regime.

We were not fully assured that the provider was effectively ensuring the prevention and control of infection. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Inadequate.

This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Staff were not adequately supported through induction, training or supervision.
- Some staff had no experience of care work prior to being employed at Niche Care Wakefield and they told us their induction had not prepared them for the role. One member of staff said, "I have to use my common sense, I do what I think is right, but I've never been shown" and another member of staff said, "We did some training at first on a tablet computer but it wasn't enough and I didn't feel able to do the job but I was told, just get on and do what you can."
- Where people had specific care needs, staff had not had the relevant training. Where training required essential practical demonstration this was not delivered. There was minimal evidence of any competency checks or supervision carried out to ensure staff supported people safely and understood the requirements of their role.
- People and relatives expressed concern about staff's skills in caring for them safely. One person told us, "There have been a couple of new starters that can't do hoisting. We had to have a meeting with the social worker." A relative said, "Once, two women came and they said they weren't hoist trained so we couldn't get [person] out of bed." Another relative told us, "They don't give the staff enough training. A girl came who only started this week. I asked her, how much training did you have? She told me, just a few things in the office for one day."

Staff did not have adequate induction, training or support. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. People's choices and agreed times of care were not adhered to and there were significant shortfalls in the delivery of care.
- Staff told us they did not have time to read people's care plans or understand their needs to be able to provide effective care. One relative told us staff did not read care records and said, "When the carer messed up [person's] medicines, she admitted to me that she hadn't read [person's] case notes properly. The notes had been sent the night before. It could have caused serious issues."
- People and relatives told us staff did not always understand the care needs. One person said, "You never know who is coming. I don't know what time they are coming. They [carers] treat me alright, but they do say 'we can't stop long as we only have 5 minutes to get to the next call'. They try their best. Sometimes they will forget little things – putting on ointment, not switching the catheter bag to the night bag. It's the situation they are put into by Niche Care." One relative said, "In the last couple of weeks we've had all sorts of carers."

They don't understand [people's] needs."

- Staff told us people's care needs were not always recorded or lacked detail for them to know what to do. For example, one member of staff said, "One person's care record just says 'skin' and I take from that they might be at risk of pressure sores, but nothing else is written down."

Systems and processes were not consistent or robust enough to ensure adequate assessment of people's needs and risks. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People's health and nutritional needs were not always met.
- People, staff and relatives told us when care was delivered on time this enabled people to have support for meals if needed. However, they consistently told us poor time keeping and staff rushing meant mealtimes were often late or missed altogether. One member of staff expressed concern about people who needed reminding to eat and drink and who relied on staff for this. They told us, "It's just not right, people sometimes see nobody from their teatime call until the next day, and if that's late they can have missed out on food and drinks for a long time." Another member of staff told us they helped with preparing food and drinks, but did not always have time to stay and support people. They said, "I make sure they've got what they need but then I have to rush to the next person."
- Staff told us they used the on-call service if emergency healthcare was needed, but this was not reliable and they sometimes had to summon help for people themselves. One member of staff said, "A few times I've had to call for an ambulance or for a person's family if I think they need some help and the on-call won't answer the phone."

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

- The service was not working within the principles of the MCA.
- Information in people's care plans was not always clearly or consistently recorded. Staff did not all have an understanding of people's needs, their mental capacity and whether they were able to make their own decisions. One member of staff said they supported a person living with dementia, but the information on their care plan was 'sketchy' and they did not know if the person could leave their home unsupervised.

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

- The poor organisation and inconsistent delivery of care, meant people were not always treated with respect, supported appropriately or their individual needs met.
- Staff told us they tried their best to be kind and caring, although this was not their experience of the management towards them. Staff felt unsupported and their workloads were such that they were frequently late to deliver people's care. One member of staff said, "It's really tough but I don't show this to the people we see, they have a right to expect good care so I do my best for them and smile even when I'm struggling." One member of staff said, "Never have enough time, its back to back and you never get a break. I was behind on a call recently and I told them at the office, they just laughed and said get on with it."
- People and relatives were keen to express the contrast between the attitude and approach of the staff and that of the management at Niche Care Wakefield. People and relatives felt staff were trying their best to support them, but there was a lack of management support.
- Feedback about the staff showed they were caring and supported people well wherever they could. One relative said, "Yes, absolutely. Their attention is to [person], they always speak with [person] ask what [person wants] them to do. They will listen to me as well. They are very polite, they have just got a rapport with [person]. It's just the management – they are failing to manage the [staff]." One person told us "Yes. They make a point of making sure I have everything I want and need until the next person comes." Another person said, "When they turn up, the quality is brilliant. They need to sort the [care staff's] timings out". "They are very nice people. If I want something from the shop they will go, and it's just nice to know that someone comes in the morning in case I need them for something."

Supporting people to express their views and be involved in making decisions about their care

- There was insufficient support or encouragement for people to be involved in their care.
- People and relatives did not always feel involved or sufficiently consulted about their care and support. They told us when they tried to make their views known to staff or those in the office, they did not feel this made a difference.
- People and relatives told us they were not routinely asked their views about their experiences of using the care service, although some people said they had been contacted in the last few days to comment on the quality of care.

Respecting and promoting people's privacy, dignity and independence

- People's dignity, privacy and independence was not promoted.
- Staff told us they tried wherever possible to support people's privacy, dignity and independence, but the timings of their calls sometimes impacted upon this. One member of staff said, "Call times do not always meet people's needs. [Person] is often helped to bed at teatime if that's the only time we can fit it in, but might not be seen again until lunchtime the next day. That's not very dignified for them if they need help to get out of bed and calls are either too early or [usually] too late." Another member of staff told us people's calls could be made after midnight, which was well past their expected bed time support.
- People told us staff usually respected their privacy, although one person said, "They come straight in the door, I shout 'come in' when anyone knocks."

Care was not person-centred and people's individual needs and preferences were not respected. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Inadequate.

This meant services were not planned or delivered in ways that met people's needs.

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

- Care was not personalised around people's needs or preferences.
- Care times were not consistent or in keeping with people's wishes or health needs. Staff rotas showed some planned 30 minute calls were only two minutes in duration and there was no management oversight to ensure people's care needs were being met. The provider said they were taking steps to ensure calls were monitored closely and recorded accurately.
- Feedback was largely negative in respect of reliability of the service and consistency of care staff, although some people reported consistency and reliability. One person said, "We are happy, the carers are brilliant and we can't fault them whatsoever but they do have poor timekeeping" and another person said, "They're brilliant – honest to god. I always have the same carers, they have been so far." However, other people's comments included, "They don't arrive on time. They're supposed to come at 8.30 in the morning and they regularly come late" and "I never know who is coming, or if anyone is even going to come at all." "They really need to get somebody in there who knows about quality care. If they have so many [service users] and not enough carers, that can't give a quality service."
- Staff told us if they were unsure how to meet people's needs, they referred to relatives where possible because 'they know more than the office'. Relatives confirmed care staff sometimes communicated with them to support people's needs. One relative said, "It gives me a lot of peace of mind, to make sure [person] is up and dressed. They [carers] are quick to ring me if there's something wrong, or they are concerned about [person]. The carer who is there will ring and I know to come over to sort it out. Communication between the carers and myself is very good."

Care was not person-centred and people's individual needs and preferences were not respected. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

- People's communication needs were not robustly considered.
- Information in people's care plans was not robust enough to ensure staff understood or met people's communication needs.

- Some people and relatives said they had not seen any records of care or been asked about their preferences for communication. Information for people was not available in a variety of ways to support their understanding.
- Staff told us they did not always know people's particular communication needs and there was little information in people's care plans to guide them. One member of staff said they supported a person whose speech was difficult to understand, but they hadn't been given any information about how best to communicate with them.

Improving care quality in response to complaints or concerns

- Complaints and concerns were not managed and there was no evidence these had led to improvements in care.
- There was a backlog of complaints, many of which were some months old and had not been addressed. Some of these had been acknowledged with a letter promising further follow up but this had not been done. People who had complained previously had cause to complain again about issues which had not been resolved.
- Some people and relatives expressed frustration and a lack of confidence in their complaints being heard and acted upon. One relative told us "The agency is not very good at handling complaints unless you put the word 'formal' on it. They don't take it seriously". Another relative said, "They don't respond to emails or phone calls. They never call back when they say they will. It's all lip service." Some people told us they had no complaints and were satisfied with their care. Some people told us they preferred to not have to change care companies, but just would like to see improvements. One relative said, "We don't want the moon on a stick, we just want a better quality of service."

Complaints were not sufficiently acknowledged, recorded, or responded to. This was a breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The new manager told us they were aware of the number of complaints still requiring a response and this was being prioritised with the support from senior managers.

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 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

- Roles and responsibilities were not clearly defined and there was a lack of understanding about how to identify risk and drive improvement.
- There were no clear and systematic processes in place to assess, monitor and improve the quality and safety of the service. The provider did not have sufficient understanding of the risks in the service or how to address any shortfalls. Where concerns had been raised, such as missed and late calls, not enough action had been taken to assess the impact of these, prevent a reoccurrence and improve quality.
- There were no robust and regular quality audits. There was no oversight from senior management to ensure the service was running well in order that people received safe care. Records were not adequately kept to demonstrate whether or how people's care needs were being met.
- People, relatives and staff overwhelmingly reported poor leadership in the service. One person told us, "Would I recommend Niche Care to anybody else? I would not. It has just lurched from one mistake to another in this area. It's quite annoying when they send different carers and I don't have a phone call. Changes of managers, changes of staff. I don't like disorganisation. "It's chaotic. I don't know who the manager is." A relative said, "It's very badly managed." Staff said managers expected them to complete calls and were aware calls were being cut short, late or missed, but without taking responsibility or supporting staff. Staff told us the on-call manager system was not reliable.
- The new manager had been in post for almost three weeks when the inspection commenced and they were still learning their role. They were working alongside senior managers, although no framework had yet been established for them to understand the priorities for improvement.

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

- There was little evidence of an open and transparent culture in the service.
- Some staff reported a poor working culture and attitude from managers which made them feel undervalued. Staff told us they frequently worked excessive hours without time for a break, and additional work was placed on them at short notice. Staff said if they asked the office staff or managers for help, this was not always supported. Some staff described management as angry, bullying, sarcastic and unapproachable and said they had been threatened with the sack and verbally abused at times. One person told us, "Some of them are dropping asleep they are so tired. It's not their fault, it's the management's fault."

They just can't keep the carers."

- There was little travel time factored in to the staff rotas and staff felt under pressure to rush their work in order to fit everyone's care in. One member of staff said, "People deserve better than this, but it is out of my hands and I can't give the care I'd like to."
- There was a lack of accountability when things went wrong. Some matters had not been referred to safeguarding as they should have been, but staff involved had left the service and there had been no follow up actions taken. There had been little action taken to identify why large numbers of staff had left the service. People and relatives consistently said they did not know who was in charge of the service.

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

- People, staff and relatives were not fully engaged or involved in the service.
 - People, relatives and staff told us there was poor communication throughout the service. One person said, "Sometimes they don't listen. If you phone up and say someone is late, they just don't ring back. They don't seem to know what everyone else is doing. They haven't got a clue." Another person said, "They are not telling me if they are late, or not coming. The old management would have phoned and would have found out why they have not come." A relative said, "The office I don't really know, but I don't rate them. I have had some trouble with the management, I get the feeling they want to shut me up".
 - There was no evidence of care staff being involved in staff meetings or briefings. Staff said they did not know who their colleagues were unless they had cause to work directly with them.
 - There was no evidence of any newsletters or surveys having been sent to people and their relatives. There was a staff survey done in June 2020 but this did not show how many staff had taken part or what management had done with the results to drive any improvement.
- There was poor communication with people and their relatives regarding contingency plans for bad weather; some relatives said they were not involved until calls had been missed. One relative said, "In the bad weather, we didn't receive a call. I had to dash up to help and I wasn't happy. It would have been nice to have received a call."
- 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.

There were widespread weaknesses in the management of the service which impacted on the delivery of safe, effective and reliable care for people. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 9 HSCA RA Regulations 2014 Person-centred care Care was not person centred; care plans lacked detail and care was not delivered in line with people's needs
Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not identified to individuals, or mitigated. People were at risk of harm because staff did not have adequate or appropriate safety related training. People did not always receive their medicines safely or when they needed them. There was not enough assurance about infection, prevention and control.
Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding matters had not been sufficiently identified or reported
Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not always acknowledged, recorded or responded to
Regulated activity	Regulation

Personal care

Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

Recruitment was not robust enough to ensure staff were suitable to work with vulnerable people

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	Regulation 17 HSCA RA Regulations 2014 Good governance There were significant weaknesses in the leadership and management of the service, impacting on people's safe care and treatment

The enforcement action we took:

We issued a warning notice to the provider

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were significant shortfalls in staffing, impacting negatively on people's care

The enforcement action we took:

We issued a warning notice to the provider