Niche Care Limited

Niche Care North Tyneside

Inspection report

Cobalt Business Exchange
Cobalt Park Way, Newcastle Upon Tyne
Wallsend
NE28 9NZ

Tel: 01912508755
Website: www.nichecare.co.uk

Date of inspection visit:
23 August 2021
27 August 2021
31 August 2021

Date of publication:
15 November 2021

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Niche Care North Tyneside is a domiciliary care agency providing personal care to adults living in their own homes. At the start of the inspection 76 people were receiving personal care support. However, the number of people receiving a regulated activity reduced during the inspection period. The registered provider had applied to CQC to remove the location of Niche Care North Tyneside from their registration. This application was being progressed by CQC during the inspection period.

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
The service was not well led. Effective governance systems were still not in place to monitor quality and deliver improvements across the service. Systems were in place to gather feedback from people, their relatives and staff. However, there were missed opportunities to respond to feedback to improve outcomes for people. The provider had not followed their own action plan developed following the last inspection to improve standards at the service.

A robust system to ensure people were protected from the risk of abuse was still not in place. We identified several safeguarding concerns which had not been reported to the local authority in line with safeguarding thresholds which exposed people to a risk of harm. Medicines were not managed safely. In addition, medicine administration records did not always demonstrate medicines had been administered to people as prescribed.

Safe infection control systems and procedures were still not in place to ensure people were protected from the risk of infection. The provider had not taken sufficient action following our last inspection to ensure staff were aware of and followed safe infection control procedures. An effective system to ensure all the risks people were exposed to, was still not in place. There were not enough staff to safely meet people's needs and safe recruitment procedures had not been followed.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The majority of staff we spoke with did not feel supported at work. In addition, not all training deemed mandatory by the provider had been delivered to staff. The nutritional needs of people were not always met, and action had not always been taken to report concerns to the appropriate health or social care professional for people with specific needs.

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

Rating at last inspection (and update)
The last rating for this service was requires improvement following an inspection in February 2021 (report published 28 July 2021) and there were multiple breaches of regulations. We issued the provider with a Warning Notice related to infection prevention and control. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection, the provider has not complied with the Warning Notice and enough improvement had not been made overall, meaning the provider was still in breach of multiple regulations.

Why we inspected
The inspection was prompted in part due to serious concerns received about people's care and treatment, staffing, missed calls and the management oversight at the service. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. This inspection was also carried out to follow up on action we told the provider to take at the last inspection.

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 the previous comprehensive inspection for those key questions were used in calculating the overall rating at this inspection.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Niche Care North Tyneside 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 monitor the service to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to person centred care, safe care and treatment, safeguarding people from the risk of harm, staffing, fit and proper persons employed and the overall governance of the service.

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
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 well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Niche Care North Tyneside

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
This inspection was carried out by two inspectors, a medicines inspector and an Expert 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 homes. The service did not have a manager registered with the Care Quality Commission. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. Inspection activity started on 23 August 2021 and ended on 16 September 2021. We visited the office location on 23, 27 and 31 August 2021.

What we did before the inspection
We reviewed information we held about the service, including the statutory notifications we had received from the provider. Statutory notifications are reports about changes, events or incidents the provider is legally obliged to send to us. We contacted the local authority commissioning and safeguarding teams and Healthwatch to request feedback. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

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 with 11 people who used the service and four relatives about their experience of the care provided. We spoke with 10 members of staff including the manager. We reviewed a range of records. This included care records for eight people and multiple medicines records. We looked at recruitment records and a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We communicated with the nominated individual of the service by email. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with six professionals who were involved with the service. We shared details of our inspection findings with the local authority safeguarding and commissioning teams.

We liaised with the local authority and CQC registration colleagues as the provider had applied to remove this location from their registration.

Inadequate

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

At our previous inspection in February 2021, an effective safeguarding system was not in place. This was a breach of Regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found sufficient action had not been taken to improve and the provider remained in breach of Regulation 13.

- An effective safeguarding system was still not in place.
- We identified multiple medicine errors which had not been reported to the appropriate authorities in line with safeguarding thresholds.
- Appropriate action had not always been taken by the provider to ensure people were kept safe. Staff reported there were regular occurrences where calls to people were missed or were extremely late and records confirmed this. All incidents where people had suffered neglect as a result of missed calls had not been reported to the safeguarding authorities.
- During the inspection we made several safeguarding referrals to the local authority safeguarding team for their knowledge and potential investigation.

The failure to have an effective safeguarding system in place was an ongoing breach of Regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our previous inspection in February 2021, there was a failure to properly assess, monitor and mitigate risks to the health and safety of people. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found sufficient action had not been taken to improve and the provider remained in breach of Regulation 12.

- An effective system to monitor and manage all risks was still not in place.
- The provider had still not ensured specific risks relating to COVID-19 had been assessed and documented. For example, there were no risk assessments in place for people at increased risk if they contracted COVID-19 due to being diagnosed with an underlying health condition.
- Lessons had not been fully learnt from the previous inspection.

The failure to have an effective system to assess, monitor and manage risk was an ongoing breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Safe recruitment practices had not been followed. We reviewed records for three staff and found shortfalls with all recruitment checks. This included gaps in the employment history for potential employees which had not always been considered in the recruitment process.
● Some staff were working without the relevant Disclosure and Barring Service [DBS] checks or risk assessments in place.

The failure to carry out relevant and robust recruitment checks for staff was a breach of Regulation 19 (Fit and proper person's employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were not enough staff employed to meet people's needs. This impacted on the ability of the service to provide safe care.
● Staff told us, and records confirmed staff did not always stay the allocated time for a care call. In addition, there were regular occurrences where staff arrived late, or calls were missed. One relative told us, "[Name] cannot relax and neither can I because they are so unreliable. [Name] will sit and wait, you know like older people do, expecting them to turn up at the times they say they will but sometimes they are really late and sometimes they don't turn up at all."
● Staff told us they were expected to work excessive hours and were not always able to take breaks.

The failure to ensure there were enough suitably competent and skilled staff were deployed was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider told us of the difficulties they had experienced in trying to recruit new staff. They were liaising with the local authority to transfer some people to alternative care providers to alleviate some of the pressure the service was experiencing.

Using medicines safely

At our previous inspection in February 2021, the provider had failed to ensure medicines policies were clear and maintain appropriate and complete records in respect of the management of medicines. This was a breach of Regulation 17 (Good governance) of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found sufficient action had not been taken to improve and the provider remained in breach of Regulations 17.

● Medicines administration records [MARs] did not always provide details of which medicines had been administered to people. In addition, MARs showed gaps in the administration of medicines with no explanations provided.
● Medicines which required specific time intervals between doses were given too close together.
● Records contained conflicting information in relation to the levels of medication support they offered. For example, the provider's medicine policy contained different medicine support levels to those recorded in people's care plans.
● Medicines audits were completed. However, a system to support robust auditing was not in place. Some issues we found during the inspection had been identified on the audits, but no action plans had been

developed. This resulted in no learning or improvement actions being implemented.

The failure to maintain appropriate and complete records in respect of the management of medicines is an ongoing breach of Regulation 17 (Good governance) of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.The failure to have an effective system in place to manage medicines safely is also 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

At our previous inspection in February 2021, an effective infection control system was not in place. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took enforcement action and issued a Warning Notice in relation to infection, prevention and control (IPC). At this inspection we found sufficient action had not been taken to improve and the provider remained in breach of Regulation 12.

● An effective infection control system was still not in place. Government guidance relating to safe working practices including the use of PPE was not always followed by staff.
● The provider completed an action plan following the last inspection to record how they would address the infection control shortfalls at our previous inspection. All of the identified actions had not been completed. For example, the provider stated all staff would be re-trained in infection control and this had not taken place.
● The provider told us they had sufficient stocks of PPE. However, some staff, people and relatives said staff did not always wear PPE. Staff said some of their colleagues would not drive to the provider's identified location to collect PPE stock due to the financial cost to them and there were no systems in place for PPE to be delivered to staff.

This was an ongoing breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet

At our previous inspection in February 2021 there was a failure to ensure care records were well maintained. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014. At this inspection we found sufficient action had not been taken to improve and the provider remained in breach of Regulation 17.

● Assessments of people's needs were completed. However, staff did not always complete all of the assessed tasks they were supposed to during support calls. In addition, staff did not always fully complete care records to evidence the tasks they had completed and to provide an update of how people had been.
● People did not always receive personalised care and support which was specific to their assessed needs and preferences. One person told us, "I don't know the people who come to care for me. It's like having strangers in your house… I never seem to get the same people twice, it's always someone different. You can tell them [staff] stuff, so they know your preferences, but then another lot arrive, they don't know you. Every week there's a new carer."
● Staff's ability to meet people's assessed needs was impacted as a result of late and missed calls. One relative said, "Mum's on the edge of her seat waiting for them [staff], and can't relax…The staff turnover seems to be really high; you rarely get the same carers coming in so feedback can be a problem because they don't ever get to know Mum or her needs and preferences."

The provider's failure to ensure care records were well maintained and contemporaneous was an ongoing breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014. Also, the provider's failure to ensure people received care which was specific to their individual assessed needs and preferences was a breach of Regulation 9 (Person-centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's nutrition and hydration needs were not always met. We identified occasions where missed calls to people had resulted in grocery shopping not being purchased meaning some people did not have access to food in their home. In addition, some missed calls had resulted in people not having access to food and drinks as they relied on staff to provide these for them.

The failure to have an effective system in place to ensure risks relating to eating and drinking were assessed

and monitored was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The failure to ensure people's well-being was maintained as a result of not meeting their nutritional and hydration needs was also a breach of Regulation 9 (Person-centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Training the provider had deemed mandatory had not always been delivered to staff. Due to staff shortages there were occasions where office staff had also delivered care to people. Evidence to show these staff had received the relevant training to enable them to carry out this role was not provided to inspectors.
- Staff had not always completed training in topics relevant to the needs of the people they supported. For example, catheter care.
- Most staff we spoke with told us they did not feel supported at work. There were gaps in the records to show staff had received regular supervision. In addition, an action plan by the provider identified staff should receive regular appraisals. Evidence was not provided to us during the inspection to show this had taken place.

The provider's failure to ensure staff were supported and received all of the relevant training necessary to undertake their job role was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This placed people at a risk of harm. Also, the failure to maintain accurate records was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- An effective system to ensure people received consistent and timely care was not in place. The communication and recording systems used by the provider meant that certain incidents were not always reported to the appropriate authorities.
- Important information regarding the health and well-being of people was not always shared with the relevant health or social care professional. For example, social workers had not been informed of instances of missed calls to people which had impacted upon the care and support they were assessed to receive.

The failure to have an effective system to ensure people received consistent and timely care was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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, and whether any conditions

on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● The manager told us no one using the service was subject to any restrictions placed upon them by the Court of Protection.
● Care records showed capacity assessments had been completed for people. However, one relative told us, "I have asked on many occasions that I should be the first port of call for any information, changes and so on. My mother gets confused and doesn't have the capacity to deal with any questions or changes and so on, but they haven't done that."
● Evidence was not available to show how capacity would be reassessed if there was a change in need for people.

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 as requires improvement. At this inspection this key question has now 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

At our previous inspection in February 2021 the provider had failed to ensure effective quality monitoring systems were in place. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection we found sufficient action had not been taken to improve and the provider remained in breach of Regulation 17.

- The service did not have a manager registered with the Commission. The provider had identified one of their managers from another of their locations to manage Niche Care North Tyneside in addition to their usual work. At the time of the inspection there were no staff working from the Niche Care North Tyneside office location.
- A system to ensure the provider met its legal requirements was still not in place. A range of audits were completed to monitor the quality at the service. These had been ineffective at identifying themes, monitoring quality or driving improvements across the service. The manager was unable to provide evidence of regular audits or other quality assurance checks. Where audits had identified shortfalls, action had not been taken to learn lessons to prevent future reoccurrences. This impacted on the quality of care people received and did not meet their assessed outcomes.
- The manager did not have oversight of all the concerns which had been raised. Some tasks had been delegated to other senior managers within the organisation. This impacted upon the manager's ability to oversee the service as they were unable to provide us with some information we requested during the inspection.
- A thorough review of medicine management had not taken place to identify the cause of the high volume of medicines errors which were occurring. No systematic review had taken place to establish the reason for medicines errors and if this was linked to late and missed calls.
- Action plans developed following the last inspection had not been fully implemented. The manager was unaware enforcement action had been taken following the last inspection in relation to the shortfalls in the infection control practices of staff. Therefore, they had not been monitoring progress against the action plan. Ongoing shortfalls were identified at this inspection in relation to safe infection control practices.
- A number of people and relatives raised concerns with us regarding the quality of care provided. We shared this feedback with the nominated individual and manager. While they had communicated with us during the inspection they did not respond to an email requesting a specific update on how they planned to

address this feedback.

The provider's failure to ensure effective quality monitoring systems were in place was an ongoing breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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

- Systems were not in place to ensure there was effective collaboration and communication with external organisations. For example, there continued to be occasions where information of a safeguarding nature had not been passed to the relevant professionals.
- The provider did not always engage with staff effectively. Actions from a survey identified ways to improve their engagement with staff. These actions had not all been carried out effectively. Most staff we spoke to told us they did not feel supported at work.
- People, relatives, visiting professionals and staff told us of the difficulties of getting through to office staff by telephone. One relative said, "They don't answer their phones when you try to call them most of the time, when I do get through they promise all sorts of things, they say they will sort things out, but they don't."
- On-call systems were ineffective. If people required assistance outside of office hours, they were diverted to staff working in Grimsby. These staff did not have access to people's records to enable them to effectively respond to the caller.

The provider's failure to ensure systems were in place for effective communication was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) 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

- The manager understood their responsibilities under the duty of candour regulation. There had been no reportable safety incidents.