Durbia Limited

Durbia Healthcare Ltd

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Durbia Healthcare Ltd is a service providing personal care to people living in their own homes. It provides short and long-term care to people within the community. At the time of our inspection the service supported 14 people including people living with dementia.

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
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

At the time of the inspection, the location did not care or support for anyone with a learning disability or an autistic person. However, we assessed the care provision under Right Support, Right Care, Right Culture, as it is registered as a specialist service for this population group.

Right Support
People did not receive their medicines safely. There was no clear guidance for specialised healthcare tasks such as oxygen therapy and catheter care which placed people at risk of harm.

People were not always supported by staff who were appropriately trained or assessed as being competent.

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.

Right Care
People's care plans and risk assessments did not cover their range of care and support needs. Staff were not guided to support people in line with legislation and good practice which meant people had not been protected from harm.

We received mixed feedback from people in relation to their care. Some people told us they didn't always feel safe with the care they received. Other people said staff were "kind and compassionate" and "willing to go the extra mile."

Right Culture:
The provider continued to not follow recruitment legislation and ensure staff deployed had the right employment checks and skills to support people safely.

The service was not well-led. There was no effective governance system in place to monitor the quality of the service provided to people. The provider continued to fail to recognise risks and concerns in relation to health and safety, employment of staff, completing records and medicine management.

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 (5 February 2020) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the provider remained in breach of regulations.

Why we inspected
We received concerns in relation to person centred care planning and risks associated with pressure care. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

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 Durbia Healthcare Ltd on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment of people including risk assessments and personalised care planning. Risks were identified in the recruitment of staff and the governance of the service at this inspection.

We imposed conditions on the providers registration to ensure people remained safe whilst the provider worked to make improvements. You can see what action we have asked the provider to take at the end of this full report.

Follow up
We will request an action plan 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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 well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Durbia Healthcare Ltd

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by 1 inspector. An Expert by Experience made calls to people, relatives and advocates to gain their views on the care provided. 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.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was announced.
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 9 October 2023 and ended on 12 October 2023. We visited the location's office on 12 October 2023.

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 and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 2 people who used the service and 7 relatives about their experience of the care provided. We received feedback from 3 members of staff including the registered manager, care coordinator and compliance manager.

We reviewed a range of records. This included 3 people's care records. We looked at 4 staff files in relation to recruitment. A variety of records relating to the management of the service, including audits, policies and procedures and training records were reviewed.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment; Learning lessons when things go wrong
At our last inspection the provider failed to ensure staff were of good character, and this placed people at risk of abuse and harm. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider was still in breach of regulation 19.

- Safe recruitment practices were not followed. Previously we had identified staff files without adequate or inconsistent referencing; this concern remained on this inspection and demonstrated the provider had not learned lessons from previous concerns or taken appropriate action to rectify them.
- Two staff files reviewed did not contain 2 references as per the provider's policy and where character references had been sought it was not clear who the referees were or in what capacity they knew the staff member.
- The records showed that recruitment checks such as work history and experience had not been systematically carried out. This placed people at risk of harm as the provider could not confirm staff were suitable for employment with their service.

Systems had not been established to assess and ensure staff were of good character. This placed people at risk of ongoing abuse and harm. This was a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
- Medicines were not administered or recorded safely. This placed people at risk of harm from not receiving their medicines as prescribed.
- National guidelines for administering medicines had not been followed. For example, staff administered medicines to people they had not prepared or dispensed. This placed people at risk of harm as staff could not confirm what medicine was being administered.
- Where people required support with oxygen therapy, care plans did not contain clear guidance for staff on people's prescribed oxygen level and staff had not always been trained to ensure it was delivered safely.
- Medicine administration records (MAR) charts were not completed in line with best practice. For example, staff signed records to show medicines had been administered at times they were not present at people homes.
- Gaps were identified in MAR charts. Staff had not recorded why these medicines had been administered and audits had failed to identify these gaps. This placed people at risk from not receiving their medicines as prescribed.

Assessing risk, safety monitoring and management

● Risks to people's safety was not consistently assessed, monitored, and managed.

● We reviewed care plans which did not contain risk assessments for peoples identified needs. For example, where people needed supported with oxygen therapy and equipment such as a ventilator, there was no guidance for staff on how to support with this equipment, or how to monitor people whilst receiving care. This placed people at risk of harm from not receiving appropriate or safe care.

● One person was identified as requiring support with a catheter. This information was not clearly recorded within their care plan. We raised this with the provider who reviewed the care plan, however the updated care plan did not contain guidance for staff on how to fit the catheter or how and when this should be emptied or monitored.

● Risks associated with specific health conditions had not been identified or mitigated, this placed people at risk of ongoing harm. For example, people with epilepsy did not have a care plan in place. This meant staff did not know how to support them in the event of a seizure.

● Moving and handling risk assessments and care plans did not reflect people's needs. For example, one person required support with a hoist. Their care plan stated the person was independent with their mobilisation. This placed the person at risk of harm from being supported or moved inappropriately.

● Some people had known risks with continence care and limited mobility and limited assessments had been recorded in relation to people skin integrity. Where professionals had implemented pressure relieving equipment this had not been recorded in peoples care plans which placed people at risk of harm as we could not confirm people were supported to use this equipment.

● Relatives we spoke with told us they were not always confident in staff's ability to keep their loved one safe. One person said, "Some staff seem very frightened on the equipment we have, and some staff haven't been trained."

● Another relative said, "My [family member] is cared for in bed and staff reposition them. However, some staff don't do this right, and I have to do it when they leave". This placed people at risk from not receiving care safely, appropriately or in line with their wishes.

As a provider you failed to ensure that you have do all that is reasonably practicable to keep people safe from harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 MCA 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.

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.

● At the time of our inspection the provider did not support anyone who had been deprived of their liberty however there was a policy in place and staff were knowledgeable about MCA should this be needed in the future.

Systems and processes to safeguard people from the risk of abuse

● People were not always protected from the risk of avoidable harm.

● Lack of training for staff, and the absence of comprehensive risk assessments and person centred care

plans placed people at risk of avoidable harm.
● There was a policy in place to support staff to raise their concerns and staff we spoke with were knowledgeable about how and when to raise their concerns.

Preventing and controlling infection
● The provider had a clear infection prevention and control (IPC) policy in place that was up to date and guided staff in mitigating risks to people from spread of infection.
● The provider was knowledgeable about IPC provided staff with personal protective equipment (PPE) to ensure people remained safe.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to implement systems and processes to assess, monitor and mitigate risk of avoidable harm to people. This was a breach of Regulation 17 (1) (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider was still in breach of regulation 17.

● People were at ongoing risk of harm because the provider did not understand the principles of good quality care and had not developed systems and processes to ensure compliance with regulations and national guidelines.
● The provider failed to identify opportunities to reduce the risks to people's safety and prevent people from experiencing avoidable harm. We found no action had been taken to embed a culture of learning lessons from previous incidents.
● Competency checks for staff on administering medicines had been completed by a staff member who had not received additional training to complete this task or signed off as competent at undertaking these checks themselves. This meant the provider had failed to identify the risk of harm to people when receiving their medicines.
● The provider failed to ensure they had a safe recruitment process and system in place. They had also failed to action previous concerns in this area. This placed people at risk of avoidable harm from being supported by staff who may not be suitable.
● Staff had not received the relevant training to ensure they could support people appropriately or safely. For example, only 45% of staff had received training in epilepsy and 54% in pressure area care. This placed people at ongoing risk of harm.
● Records showed and relative feedback confirmed that untrained staff members were supporting people with specialised health care tasks such as ventilators. This placed people at ongoing risk of harm from not receiving their care safely.
●The provider failed to put reliable and effective monitoring systems in place to ensure there was good oversight of the service in relation to care planning, risk management, health and safe medicines management. This meant the provider had failed to ensure they identified risks, concerns and had not improved the care provided.

The provider failed to ensure good governance systems were in place to assess, monitor and mitigate the

risks to people, maintain securely accurate or up-to-date records of people's care or the management of the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Working in partnership with others
● The provider did not always work in partnership with other professionals effectively.
● People and their relatives told us professionals such as GP's and district nurses worked with care staff well. However, their advice and recommendations were not clearly documented within people's care plans. This place people at risk of harm as the provider could not evidence that recommendations and guidance was being followed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The culture was not consistently person centred and the provider did not record outcomes for people.
● The provider failed to ensure staff were provided with information to guide them on how to best support people in line with legislation, good practice, and policies. For example, not all staff had received relevant training, and care plans and risk assessment did not reflect people's needs.
● Although we identified significant concerns at this inspection, feedback we received from people's relatives was positive. One relative told us, "I feel my [relative] is very safe with the staff who support them." And other said, "I think the staff are friendly and kind, the care means everything to us. We wouldn't be able to function without it."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider engaged with people using the service but did not always act on the feedback they received.
● The provider had sought feedback from people using the service through a written questionnaire; where responses had been received that identified issues or concerns there was no evidence of any actions being taken to address these concerns.
● Regular team meetings were held, and staff received supervisions. Records of meetings showed staff received updates and were given the opportunity to raise issues or concerns however there was no evidence to show the provider acted on these concerns.

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 provider did not always understand or act on their duty of candour. As demonstrated in the safe section above the provider had failed to act on previously identified risks such as recruitment and had not taken appropriate steps to mitigate risks to people. They had also failed to implement the changes needed so they met regulatory requirements and the law.
● There was a complaints policy in place and people and their relatives told us they knew how to raise concerns if they felt this was needed.
● One person said, "I raised a concern about a staff member who visited, and the manager acted very quickly, I was very happy with their response."

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure that people received safe care and treatment. Medicines were not administered or recorded safely and risk were not assessed or mitigated.

The enforcement action we took:

We imposed a condition on the provider registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure effective governance systems where in place to identify and monitor ongoing risks to people.

The enforcement action we took:

We imposed a condition on the provider registration.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure fit and proper person were employed. Appropriate checks such as referencing, experience and work history were inconsistently obtained.

The enforcement action we took:

We imposed a condition on the provider registration.