Diamond Resourcing Plc

Better Healthcare Services (Colchester)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Better Healthcare Colchester is a domiciliary care agency. The service provides personal care to people living in their own homes in the community. At the time of this inspection, the service provided support to 132 people.

People's experience of using this service and what we found
People were not always safe using the service as missed and late calls meant people were being left without the care they needed. People were not always safeguarded from poor care as there were not enough staff to care for people using the service.

Risk assessments did not provide assurances people were receiving the care they required, and, in the way, they needed it. Risks to people's safety had not been reviewed or care plans updated with their up to date needs.

People's medicines were not always given at the time prescribed. The lack of available information, regular audits and analysis of errors meant we could not be assured people received their medicines safely to manage their physical and/or mental health needs.

The service had not been consistently managed and there had been lack of clear management oversight. The role and responsibilities of office-based staff were not robust and clear for them to carry out their roles well. Quality assurance processes were not in place for the safety of the service and the management of records was disorganised.

Systems to control and prevent the risk of infection were in place. The service worked in partnership with other agencies and professionals for the benefit of people they supported.

Rating at last inspection
The last rating for this service was good (published 21 December 2018).

Why we inspected
The inspection was prompted in part due to concerns received from members of the public, staff and the local authority about risks to people's health and safety, late and missed calls and staffing issues. A decision was made for us to inspect and examine those risks.

We have found evidence the provider needed to make improvements. Due to the nature of the concerns, we only inspected the key questions of safe and well led. You can see what action we have asked the provider to take at the end of this full report.

Enforcement

We found three breaches of the Health and Social Care Act 2008 in relation to safe care and treatment, staffing and good governance.

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
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not well led.

Details are in our well-led findings below.

Better Healthcare Services (Colchester)

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 one inspector.

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 registered manager employed at the service.

Notice of inspection
We gave a short period notice of the inspection to be sure the provider or manager would be in the office to support the inspection.

What we did before the inspection
Prior to our inspection we reviewed information we held about the service. This included safeguarding referrals, concerns and statutory notifications that had been sent to us. A notification is information about important events which the service is required to send us by law.

The provider was not requested to complete a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they

plan to make. As part of planning we sought feedback from other agencies such as the Local Authority and we used this information to plan our inspection.

During the inspection
We spoke with nine staff including the director, manager, coordinator, field care supervisor in the office and had contact with care staff. We spoke with six people and three relatives of people who used the service about their views. We reviewed four care plans, medicine administration records, two recruitment files, and records relating to the quality and safety monitoring of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. They sent us information as requested to help us make a judgement about the service.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk people could be harmed.

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

- Risks to people's health and safety were not always appropriately assessed, monitored and recorded. Care plans did not always contain up to date information about the risks people may face in their day to day lives. For example, risk of falls, moving and handling people, use of equipment and pressure care.
- Some people's risk assessments were a tick box exercise, completed by a staff member with no oversight, supervision and guidance of how to mitigate the risks identified and keep people safe.
- Risks had not been reviewed to ensure staff were providing the correct care for people and in the right way. Information about people's needs such as risk of choking, of having seizures, and falls was not available to inform staff in how to respond to their needs safely.
- People were being left unsafe and uncared for as they experienced late and missed calls. People and relatives told us staff had often been late or not turned up at all. One person said, "They rang up from the office and said, "I am sorry, but I don't have anyone to put you to bed tonight." I said to them, what do you expect me to do? And they just said, "Sorry we just don't have the staff." A family member said, "[Relative] gets very distressed, confused and anxious if they are not on time. These late calls are causing a big problem for them."
- Care staff were aware of their responsibility to safeguard people from harm and report to a manager appropriately. We had received safeguarding concerns regarding people's safety. Safeguarding concerns and complaints had not been addressed by management in a timely way. However, a process was now in place for the new manager to address all outstanding safeguards and liaise with the local authority to ensure people were safe.
- People did not always get their medicines as prescribed and in a timely way, due to missed and late calls.
- We saw people's medicines were not always recorded or updated, for example, lack of information for people with epilepsy or diabetes who required specific support.
- Records were not completed properly to understand if people had received their medicines. Staff had not signed to say they had given medicines and we saw gaps and errors in the medicines administration records which were unexplained. People had been put at risk as staff did not follow the correct procedures.
- All staff had not completed up to date refresher medicines training and checks had not been undertaken to ensure all staff were competent in administering people's medicines.
- Lessons had not always been learnt to ensure quality and safety improved for people and staff. No action had been taken to analyse and take action about the missed and late calls to prevent people from being at harm.

The systems to assess and manage concerns, risks and medicines were not robust to keep people safe. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● The service did not always have enough staff employed and deployed to meet people's needs. The director told us there was a problem over the Christmas and New Year period with sickness and lack of management of the rota, which had resulted in missed and late calls. One family member said, "I saw the morning staff member leaving and the lunch time staff member arriving when I was going to [relative's]. It's not good enough"

● The director had allocated staff quickly to manage the rota arrangements which had reduced the amount of missed and late calls. However, the director told us they had a problem with enough staff in certain areas and were focussing on how to improve this as a matter of urgency.

● The director reassured us recruitment was underway with four new staff. They were participating in training on the day of the inspection. These staff would be ready to commence work within the next two weeks.

● The service had a recruitment process in place. Relevant checks on new staff had been completed however, we asked the director to review their policy regarding the taking up of references to ensure staff were safe to work with people in the community.

People did not always receive a consistent and reliable service from staff. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● Staff told us they were supplied with gloves and aprons. People confirmed that staff were hygienic and used protection as and when needed.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The service was not always well-managed and not everyone received a safe and high-quality service.
- Changes to the staffing of the service had meant instability and inconsistency in terms of management and oversight. Roles and responsibilities of staff needed to be reviewed so there was enough staff with the right skills to manage the administrative tasks assigned to them.
- Quality assurance and governance arrangements at the service were not reliable or effective in identifying all the shortfalls in the service. A computerised system recorded late and missed and cancelled calls, but this was not audited to look at the outcomes for people.
- No arrangements were in place to monitor the service's recruitment practices, staff support and communication processes. Some staff told us they had not received any supervision or checks on their ability to carry out their job well. One staff member said, "I am glad I know what I am doing. We just get on with our work as we know people well. As long as we chat with each other then we know our work gets covered." Communication and social media processes such as the out of hours call system and the use of WhatsApp needed reviewing to ensure they were fit for purpose.
- Systems required improvement to ensure information could be easily located. Records such as care plans, risk assessments, medicines, daily notes were difficult to access both on paper and electronically. Paper and electronic records we viewed were incomplete, incorrect and disorganised.

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

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- We saw evidence when the lack of staff availability over the Christmas period was discovered, letters were sent to people telling them their service may not be provided as per their plan of care during that period, with an apology.
- The director and staff had been open, honest and helpful during the inspection. They were committed to putting the necessary improvements in place to ensure people received good care and staff had a good place to work.

● A new manager was in post and, together with the director, were being proactive in dealing with safeguarding issues and the safety and quality of the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
● People told us the staff included them in their day to day care. One person said, "They always ask me what I want done first, my choice." A relative said, "The staff generally involve [relative] but they have to know how to do this in the right way, luckily most do."
● Care staff felt supported by the office staff although not involved in service development or improvements. Office staff were not always consulted about plans to improve the service, although they had vital roles to play in its delivery and quality. The director ensured us staff would play a greater role in their improvement plan going forward.

Working in partnership with others
● We saw evidence the service worked together with a range of professionals. They shared information and sourced support, equipment and advice for the benefit of people they supported.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health and safety had not been assessed, monitored and recorded to meet their needs.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff to provide adequate care for 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 Systems were not robust enough to demonstrate effective oversight and continuous improvement of the service.

The enforcement action we took:

A warning notice was issued to the provider.