Niche Care Limited

Niche Care Sheffield

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Niche Sheffield is a domiciliary care service which provides personal care to adults with a range of support needs in their own homes. At the time of this inspection the service was supporting approximately 240 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
We received mixed views from people and relatives about the quality of care. Some were satisfied with the quality of care and made positive comments about the staff. Comments included, "I have nothing, but praise for the carers" and "Yes, they [staff] are looking after me okay. They are all very pleasant." Some told us the lack of regular care workers and inconsistent calls times impacted on the quality of their care. Comments included, "There is no consistency of care" and "A few weeks ago, two carers came in who just didn't know what to do."

We checked to see if enough improvement had been made so people experienced continuity of care and experienced consistent call times. At this inspection we found further improvement was required.

Systems in place to ensure people were protected from abuse and improper treatment required improvement. Care staff were aware of their responsibility to report concerns or changes in people's needs. However, some staff were not confident these were recorded or/and actioned by office staff. Care staff told us the registered manager responded to concerns promptly and took appropriate action.

The provider had not ensured each person using the service has an accurate, complete and contemporaneous care plan in place. We found the management of medicines required improvement. Most people and relatives told us staff used gloves, masks and aprons appropriately whilst supporting them or their family member.

The providers recruitment processes required improvement. Some staff felt supported, whilst others felt unsupported and not valued. The registered manager told us it had been challenging to deliver regular supervisions during the pandemic. Staff, people and relatives shared concerns about the training of new inexperienced staff. The registered manager told us all staff would complete the new content training by the end of May 2021.

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 provider had systems in place to engage and involve people using the service and their representatives.

However, relatives and people shared concerns about the poor response to their calls to the office. Staff did not always ring back as promised. There were missed opportunities to continue to learn and improve service delivery.

The systems in place to assess, monitor and mitigate the risks relating to the health and safety of people were not effective in practice.

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

Rating at last inspection
The last rating for this was requires improvement 18 February 2020.

Why we inspected
The focussed inspection was prompted in part due to concerns received about the safety, quality of care and management of the service. The information CQC received indicated concerns about the safe care and treatment of people. This inspection examined those risks. We undertook a focussed inspection to review the key questions, safe, effective and well-led only.

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

The last rating for this service was requires improvement (published 18 February 2020). The service remains rated requires improvement. The service has been rated requires improvement for the last two consecutive inspections.

We found evidence the provider needs to make improvement. Please see the safe, effective and well-led sections of the full report.

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 Niche Care Sheffield on our website at www.cqc.org.uk.

Enforcement
We identified breaches in relation to the management of people's risks, records and quality assurance.

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.

Please see the action we have told the provider to take at the end of this report.

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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below

Niche Care Sheffield

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.

The was a focussed inspection. The information received by the CQC indicated concerns about the management and safety of the service. This inspection examined those concerns.

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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The inspection was announced. We gave a short period notice of the inspection because the location provides a domiciliary care service and we needed to be sure that someone would be available to support us with our inspection.

Inspection activity started on the 7 April 2021 and ended on 23 April 2021. We visited the office location on the 20 April 2021.

What we did before the inspection
We reviewed the information we held about the service, which included correspondence we had received,

and any notifications submitted to us by the service. Statutory notifications are information the registered provider is legally required to send us about significant events that happen within the service. 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 contacted social care commissioners who help arrange and monitor the care of people using the Niche Care Sheffield. We also contacted Healthwatch Sheffield. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all, of this information to plan our inspection.

During the inspection
We spoke with five people who used the service and 13 relatives about their experience of the care provided. At our visit to the office we spoke with the registered manager, the regional operations manager and the director of operations. We contacted 21 care staff and eight staff provided feedback about their experience of working for the service.

The registered manager sent us a range of records prior to our visit to their office location. This included records relating to the management of the service, including policies and procedures. This enabled us to review these records and reduce our time at the office location.

We reviewed a range of records. This included reviewing seven people's care records. We also reviewed the systems in place to manage people's medicines safely. We looked at two staff files in relation to recruitment and support provided.

After the inspection
We obtained clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management; Using medicines safely
• People's individual potential risks were assessed, and measures put in place to reduce and manage the risks. However, people using the Niche night support service had not had their risks assessed. The director of operations took immediate action in response to our concerns. They told us a Niche care plan and risk assessment would be completed.
• Some people experienced inconsistent call times so their risks were not managed effectively. This was reflected in people's rotas. This resulted in some people not being supported appropriately with their personal care. For example, one person told us their catheter bag would overflow when their calls were late. Another person told us they need repositioning every four hours, but their calls were not delivered consistently.
• The provider did not have enough oversight of the management of people's medicines using the night service to ensure they were proper and safe. The director of operations took immediate action in response to our concerns.
• Some people using the service required time critical or time sensitive calls. The system in place to ensure these calls were delivered at the right time required improvement. Some calls were being delivered over an hour early or an hour late in March 2021. Care staff told us they were not always able to deliver these calls on time, due to the number of calls assigned to them and lack of travelling time.
• The guidance in place to help staff decide when to administer medicines prescribed 'when required' needed to be more detailed. For example, how the person communicated they required the medicine or non-verbal cues. This meant there was a risk these medicines might not be used safely or to best effect.
• The guidance in place for the application of people's creams needed to be more detailed to ensure it was applied correctly. For example, the site and directions of application; thinly, liberally, or as a soap substitute.

This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
• Most people did not express any concerns about their safety. Some people described how the delivery of inconsistent and late calls caused anxiety.
• There were systems in place to safeguard people from abuse and avoidable harm. However, during the inspection one relative shared concerns about their family member's care. We made a referral to the local safeguarding authority. The service had been aware of these concerns, but they had not reported them to the local safeguarding authority. We shared this feedback with the registered manager and the providers

senior managers. This showed the systems in place to ensure people were protected from abuse and improper treatment required improvement.
• Staff had undertaken safeguarding training. Care staff were aware of their responsibility to report concerns or changes in people's needs. However, some staff were not confident these were recorded or/and actioned by office staff. Care staff told us the registered manager responded to concerns promptly and took appropriate action.

Staffing and recruitment
• At the last inspection we found there were enough staff deployed to cover people's calls, but some people experienced inconsistent calls times. We checked to see if enough improvement had been made so people experienced continuity of care. At this inspection we found further improvement was required.
• Some people told us they received support from regular care workers and the calls were delivered generally on time. One relative said, "The most important thing is they should provide regular carers for mum, and they do." However, some people did not have regular care workers, they did not receive their calls on time and/or the right amount of time. Comments included, "They came in today at 10:40am for my breakfast – far too late" and "It should be a 15-minute call, but sometimes they only stay for, two, four or five minutes; a very quick visit." Two relatives told us their family member had experienced a missed call.
• Most care staff told us the service did not have enough staff. Comments included, "No, poorly managed, take on too many service users when there isn't enough staff to manage the calls we already have so we get extra work loads and no break" and "The company don't have enough staff and due to this each round is full of calls so everyone is rushed off their feet." The registered manager told us there had been a significant increase in staff unexpected absence, often at short notice due to COVID-19. Staff had tried to provide continuity of care wherever possible. The provider was actively recruiting additional care staff for the service.
• Pre-employment checks for new staff, to check they were suitable to work at the service were completed. We found a gap in one staff member's employment which had not been followed up. The registered manager told us they would obtain this information.

Learning lessons when things go wrong;
• There were systems in place to learn from complaints, accidents and incidents to identify trends and common causes. However, the March 2021 branch audit showed some of those systems had not been effectively operated. For example, the quarterly analysis of complaints had not been completed for the last two quarters of 2020.
• Some lessons had been learned and changes made to the service. The results of a service user survey in November 2020 had been used to make changes to improve the service.

Preventing and controlling infection
• Most people and relatives told us staff used gloves, masks and aprons appropriately whilst supporting them or their family member. We were informed about some isolated incidents of staff not always wearing their mask and/or apron whilst providing personal care. We shared this feedback with the registered manager.
• Staff had access to personal protective equipment (PPE) such as gloves, masks and aprons. Staff spoken with told us they had a good supply of PPE.

Requires Improvement

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law;
• The service completed an assessment of people need's and choices considered aspects of their needs and the information was used to develop written care plans and risk assessments. Protected characteristics under the Equality Act were considered.
•The system in place to ensure an assessment was completed prior to a person starting to use the service required improvement. For example, one relative told us their family member had been using the service for two weeks. A risk assessment and care plan had not been completed. They subsequently stopped using the service. One person told us they started using the service at the beginning of April 2021 and they still did not have a care plan. They had asked staff for this to be completed.
• One care plan contained significant contradictions. We shared this feedback with the registered manager, so appropriate action could be taken

This showed there was a risk of people not receiving appropriate care. The provider had not ensured each person using the service has an accurate, complete and contemporaneous care plan in place. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People and relatives had mixed views about the quality of care. Some were satisfied with the quality of care and made positive comments about the staff. Comments included, "I have nothing, but praise for the carers" and "Yes, they [staff] are looking after me okay. They are all very pleasant." Some told us the lack of regular care workers and inconsistent calls times impacted on the quality of their care. Comments included, "There is no consistency of care" and "A few weeks ago, two carers came in who just didn't know what to do."

Staff support: induction, training, skills and experience
• Staff shared concerns about the training of new inexperienced care staff. They told us they would benefit from additional training and working alongside a more experienced care worker. The registered manager told us the training provided to staff had been re-evaluated. The trainers were being upskilled and mentored to deliver new processes. All staff would complete the new content training by the 26 May 2021.
•People and relatives made positive comments about their experienced regular care workers. One person said, "Yes, our regular carer is excellent." Some relatives told us the staff new to care would benefit from further training and support. Relatives comments included, "The new ones do seem to be thrown in at the deep end. They seem to shadow for a week, then they are on their own" and "These are young girls are coming in with no experience at all. They just do not know what to do."

• We received mixed views regarding the support provided to staff. Some staff felt supported, whilst others felt unsupported and not valued. The registered manager told us it had been challenging to deliver regular supervisions during the pandemic. Staff had been given access to an open-door support policy. They told us all supervisions and appraisals that were due would be scheduled to be completed by the end of April 2021.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support:
• The service had processes for referring people to other services, where needed.
• People told us care staff contacted community health professionals and their relatives when they were feeling unwell.
• Staff sought advice from community health professionals such as the GP and district nurse. This process supported staff to achieve good outcomes for people and to help people maintain their health.

Supporting people to eat and drink enough to maintain a balanced diet
• People were supported with their health and dietary needs, where this was part of their plan of care.
• People told us they were asked their meal and drink choices by staff. Relatives told us their family member was supported appropriately with meals.

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 working within good practice guidelines.
• At the time of the inspection none of the people supported by the service had a Court of Protection Order in place.
• People told us care workers consulted them and asked for their consent before providing care and support.

Requires Improvement

Is the service well-led?

Our findings

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

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

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

• At the last inspection we found the service required improvement. At this inspection we found not enough improvement had been made to ensure all the people using the service experienced high quality, person centre care.
• The registered manager had started managing the service in October 2020. We received positive feedback about the new manager from care staff and the changes they had made. However, some care staff did not feel valued and felt overworked. They told us the communication from the office was often poor. They told us the office staff did not always respond to their calls for assistance. One staff member commented, "The office / management say to ring them, but on call either doesn't answer or they say to ring office tomorrow because they've got other 'emergencies' to respond too and they're too busy. If we ring the office certain staff seem to pass it off and say they'll look into it, but nothing ever gets done. A couple of supervisors are brilliant and do help."
• People and relatives made positive comments about the care staff who regularly supported them or their family member. They told us the communication from the office required improvement. Comments included, "They need to improve communications when nobody comes or is late" and "I don't really want to change agency, but I want them to change and improve. Especially the office."
• Systems were in place to engage and involve people using the service and their representatives. For example, some people had received a survey or a call from the office. However, some relatives and people shared concerns about the response to their calls to the office. Comments included, "I ring the office, but they are a bit of a brick wall," "They [staff] never get back to you when you phone up. They [staff] are not professional, they say they'll look into things, but they never do" and "When we phone up, they [staff] are rude and unresponsive." This showed the culture within the office required improvement and there were missed opportunities to continue to learn and improve service delivery.
• People's care rotas, the feedback from people, relatives and staff showed the scheduling and monitoring of people's calls required improvement.
• The service worked with other agencies such as the local authority and clinical commissioning groups who commissioned care for some people living in the home. However, the provider's decision to utilise another

provider's care records to deliver night calls had not fully considered the risks to those individuals.
• The March 2021 branch audit highlighted systems in place to assess, monitor and improve the quality of the service had not always been completed. The auditor had also found CQC had not been notified of five safeguarding incidents. The provider is legally required to submit these notifications in line with the Health and Social Care Act. The audit also showed shortcomings in staff recruitment records. This showed the system in place to ensure all pre-employment checks were completed required improvement.

Our findings during the inspection showed the systems in place to assess, monitor and mitigate the risks relating to the health and safety of people were not effective in practice. 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
• The provider had learned from mistakes and admitted when things went wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

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 The assessment of people's individual potential risk and/or the measures in place to reduce and manage the risk to the person required improvement. The provider had not done all that was reasonably practicable to mitigate any such risks including those relating to medicines.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance We could not be assured the provider had effective systems or process in place to assess, monitor and improve the quality and safety of the service provided. The provider had not ensured each person using the service has an accurate, complete and contemporaneous care plan in place.