Betna Agencies Ltd

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Inspection report

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17 December 2020
26 January 2021

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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
Betna Care Agency Ltd is a domiciliary care service providing support for up to 27 people, the majority of whom receive personal care. The service provides care to people living in their own homes in Nottingham.

People's experience of using this service and what we found
Staff pre-employment recruitment checks did not provide adequate assurances staff were suitable for their job role. Staff were not always trained or had their competence checked to ensure they had the skills to care for people. Staffing was not always sufficient to ensure people received safe care.

Risk assessments and care plans were not always in place. Equipment was not always used safely. Medicines management and administration did not always follow recommend guidance.

Staff did not have sufficient knowledge on identification of abuse and how to report safeguarding concerns. Systems to learn from when things had gone wrong were not in place.

Not all staff had access to policies and procedures, including for the management of Covid-19 and infection prevention and control. Audits of the quality and safety of services provided were not in effective operation. People's views on the service were not used to inform improvements.

The registered manager had not communicated clear plans for the service to be managed in their absence. They had not displayed the CQC rating in their office or on their website as required. They had not submitted statutory notifications as required.

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

Rating at last inspection
The last rating for this service was good. (Report published 23 October 2018)

Why we inspected
We completed this inspection due to concerns over recruitment practices.

This report only covers our findings in relation to the Key Questions Safe and Well-Led. The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion, were used in calculating the overall rating at this inspection. The overall rating for the service has deteriorated to Inadequate. This is based on the findings at this inspection.

Enforcement
At this inspection we found a breach of regulation 12 (Safe care and treatment), regulation 19 (Fit and proper persons employed) and regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014. 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 continue to monitor information we receive about the service until we return to inspect 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?

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.

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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 inspection visit on 17 December 2020 was a targeted inspection to check the provider met the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation19 (Fit and proper persons employed). We expanded the inspection to a focussed inspection of safe and well-led and visited the office on 26 January 2021. We made phone calls to relatives and staff on 28 and 29 January 2021.

Inspection team
This inspection on 17 December 2020 and 26 January 2021 was carried out by two inspectors. Phone calls to staff and relatives were made by two assistant inspectors on 28 and 29 January 2021.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats and specialist housing.

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

Notice of inspection
The first day of this inspection was unannounced. We gave a short amount of notice for the second day of inspection. This was because we needed to arrange access to the office and ask for the registered manager to arrange for us to be able to contact people using the service, their relatives and staff as part of the inspection. We also needed to check the current Covid-19 status for staff who worked at the office where we would be inspecting.

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 Healthwatch. 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 the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with the registered manager and office administrator who also worked as a carer. We made phone calls to 10 care staff and two relatives on 28 and 29 January 2021.

We reviewed a range of records. This included seven people's care records and medicines records. We looked at 25 staff files in relation to their recruitment. A variety of records relating to the management of the service, including policies were reviewed.

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

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

Staffing and recruitment

- Staff were not recruited safely. Recruitment checks were not always conducted to show people were of good character and had the suitable skills and competence to care safely for people.
- We found a lack of records of staff employment and gaps in employment history had not been explored. Two references were not in place for all staff as required by the providers recruitment policy. This meant that the provider could not be sure that the right staff were employed to work with vulnerable people.
- The records for new members of staff did not show if they had received induction training or supervision, even though they had been working with people on their own. This left people at risk of being supported by staff who were not suitable to work with vulnerable people.

Recruitment processes were in followed to ensure staff were suitable to work at the service; this placed people at risk of harm. This was a breach of regulation 19 (Fit and proper persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staffing was not always sufficient as only one member of staff was scheduled to assist people who used moving and handling equipment that would require two staff members to operate it to ensure safety. This meant people may not be moved safely.
- Staff were not always knowledgeable about people's needs, for example one staff member told us they did not know much about pressure area care despite caring for a person with these needs. Another staff member cared for a person with epilepsy and told us they had not been trained in this area of care. This put people at risk of harm if their condition deteriorated.

Assessing risk, safety monitoring and management

- Risk assessments were not always in place and when risk assessments were in place they did not contain sufficient detail to clearly reduce risks. For example, equipment used to help people mobilise had not always been risk assessed and people at risk of pressure area damage had no risk assessment in place. One person used bed rails and no risk assessment was in place. They also had risks associated with smoking in bed and these had not been adequately assessed. This placed people at risk of harm.
- Staff told us they did not always use equipment to help people mobilise safely. For example, staff told us they would use a standing hoist on their own instead of with two members of staff. This placed people at risk of harm. Another staff member told us they would only call an ambulance following a fall if they were on their own and could not get the person back into a safe position.
- Care plans were not always complete, accurate or contained sufficient detail. For example, equipment to help people mobilise and continence aids had not been included in their care plans. This placed people at risk of unsafe and inconsistent care.

Using medicines safely

● Body maps or further instruction to staff on where creams should be specifically applied to people's bodies were not always in place. This meant people may not get their medicines as prescribed.

● Staff told us instructions on boxed medicines were not always reflected on people's medicines administration record (MAR) charts. This meant accurate and complete medicines administration records were not always in place and people may not get the correct dose of medicine.

● Staffs' competency to administer medicines had not been checked. This meant staff may not have the skills and knowledge to administer medicine safely.

Systems and process to safeguard people from the risk of abuse: learning lessons when things go wrong.

● Systems were not in place to learn lessons when things went wrong. The provider had not recorded what actions they had taken in response to two previous safeguarding outcomes investigated by the local authority.

● Staff told us there was no accident book kept in the office to record accidents and near misses. This placed people at risk as measures were not in place to reduce the chance of recurrence.

● When we spoke with staff we were not assured they had sufficient knowledge and understanding of safeguarding vulnerable people. We found staff had recorded incidents but had not assessed whether a safeguarding referral should be made.

● People were placed at risk of harm as staff knowledge and understanding of safeguarding was not sufficient and evidence to show safeguarding referrals were made when needed was not in place.

Preventing and controlling infection

● COVID-19 care plans had not been put in place when staff had provided care to people with COVID-19. This meant staff would not have clear instructions on what care to provide.

● Not all staff knew or could access the policies and procedures on the management of COVID-19 and infection prevention and control. This meant people were at risk from inconsistent care as staff did not always have access to policies and procedures and care plans.

Staffing was not always adequate and risks, including those for infection prevention and control were not always assessed and mitigated; safeguarding knowledge and processes were not adequate; medicines management did not always follow recommended guidance and care plans did not always contain accurate information. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. 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.

- The registered manager was also the provider. On our inspection visit on 26 January 2021 they were not in the UK and told us they would be away for three weeks. This was due to personal circumstances. They arranged for a member of staff to support our inspection at the providers office. The registered manager told us they were still managing the service remotely and had nominated a care coordinator to complete some tasks, such as distributing Personal Protective Equipment (PPE) to staff in their absence.
- Not all staff knew the registered manager was not in the country and staff were not clear on who was responsible for reviewing people's needs if they changed whilst the registered manager was away. We found the arrangements made to cover the absence of the registered manager were not recorded in the business contingency plan.
- The registered manager had not notified us as required about allegations of abuse and for their period of absence.
- Despite requests to see audits and checks on the quality and safety of care we were not sent any completed audits to review. We found shortfalls in people's care plans with missing or out of date information. We were not assured there were systems and processes in place to ensure quality and safety of care was being checked and improved and actions taken to identify and mitigate risks. We were concerned that there was not an effective system in place to identify shortfalls in the service and make improvements.
- Care records, including care plans, risk assessments and medicines charts were not always accurate or complete and did not reflect people's needs effectively. Other records related to the recruitment of staff and governance of the service were not always accurate or complete and put people at risk of receiving poor quality care.

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; Continuous learning and improving care

- The provider had not displayed their CQC rating in their office location and on their website as required.
- We asked to see records that detailed investigation and follow up into two safeguarding incidents the local authority had advised us of. We were not shown any records to show how these had been investigated or followed up. We were therefore not assured the registered manager's actions demonstrated a duty of candour or that opportunities for continuous learning and improvements to care were taken and acted on.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering

their equality characteristics

● We did not see evidence to show how feedback from people, staff and other professional on the care and service provided had been gathered and used to inform and improve the service, despite asking for this.

● Relatives we spoke with told us they had not received any requests for feedback on the care their family member received. We were not assured the registered manager promoted a person-centred culture that was inclusive as they were not able to show us how people, staff and other professionals had been engaged,

Working in partnership with others

● Care plans were not always clear on what aspects of care were the responsibility of other healthcare professionals. For example, some people had complex care needs and care plans did not detail in sufficiently when other professionals should be contacted for support and advice.

Systems and processes designed to assess, monitor and improve the quality and safety of the service had not always been operated effectively. Records were not always complete or up to date; feedback mechanisms to improve the service were not operated effectively and systems to learn from investigations were not in place. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Nursing care Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to operate effective recruitment procedures to comply with legal requirements. 19 (1) (a) (b) (c) (2) (a) (b)

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
Nursing care Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way as risks were not always assessed and mitigated, staff did not always have the skills and competence to meet peoples needs, equipment was not always used safely, the proper and safe management of medicines was not always followed and actions to ensure infection prevention and control measures were followed were not always in place. 12 (a) (b) (c) (e) (g) (h)

The enforcement action we took:

We served a Notice of Decision and imposed condition on the provider's registration.

Regulated activity	Regulation
Nursing care Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established and effectively operated to ensure the quality and safety of services was assessed, monitored and risks mitigated. Records were not always accurate or complete. Systems to seek and act on feedback to evaluate and improve services were not operated effectively. 17 (a) (b) (c) (d) (e)

The enforcement action we took:

We served a Notice of Decision and imposed condition on the provider's registration.