Huggies Cares Limited

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Inspection report

7 Buckingham Road
Cheadle Hulme
Cheadle
SK8 5EG

Tel: 01616373383
Website: www.huggies-cares.co.uk

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19 January 2021
20 January 2021
21 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
Huggies Cares Limited provides personal care to people living in their own homes in the community. Not everyone who used the service received personal care. Care Quality Commission (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. At the commencement of our inspection the service was providing personal care to 14 people. However, during the inspection period, this figure decreased as the local authority was in the process of removing packages of care due to concerns about the safety of the service.

People's experience of using this service and what we found
The provider had not ensured people's individual risks had been assessed and managed. There were no Covid-19 risk assessments and risk management plans in place for the service, staff and people who use the service. People's medicines were not always managed safely.

The provider had not ensured people were protected from the risk of abuse. We raised two safeguarding alerts with the local authority during our inspection. People did not always receive their care visits on time, or the call was missed entirely, and this placed people at the risk of harm.

The provider had not ensured there was adequate and effective management oversight of the service. There was no manager is place and the service was being co-ordinated by someone who had no experience of care or management. There were no support mechanisms in place for this staff member. Records were out of date and there was no quality monitoring of the service. There had been no registered manager at the service since September 2020.

Staff were providing care to people in the community but had not been provided with suitable training, supervision and competency checks. Staff training was delivered by persons who were not qualified to do so.

Staff had not undergone the necessary, legal safety checks to ascertain their suitability to work with people who may be vulnerable. Staff were providing care to people in their own homes without first obtaining assurances of DBS checks and suitable references.

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 (published 28 June 2019).

Why we inspected

We received complaints and whistle-blower concerns in relation to missed care visits, safe recruitment practice, staff training levels, medication errors, poor levels of care, safeguarding incidents and inadequate management of the service. As a result, we undertook a focused inspection to review the key questions of safe 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 overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

We requested assurances from the provider to mitigate any risks to people; however, we were not reassured with their response.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Huggies Cares Limited 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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to medicines safety, risk assessments, safeguarding people from abuse, missed care calls, safe recruitment practice, staff training and supervision and inadequate management and 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
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 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.

Huggies Cares 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 Care Act 2014.

Inspection team
This 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 homes.

The service did not have a manager registered with the Care Quality Commission. A registered manager 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
This inspection was unannounced.

Inspection activity started on 18 January 2021 and ended on 21 January 2021. We visited the office location on 21 January 2021.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and the local Healthwatch team. 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. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service and five relatives about their experience of the care provided. We spoke with seven members of staff including the care co-ordinator, the office assistant, and care assistants.

We reviewed a range of records. This included three people's care records and medication records. We were provided with a staff matrix detailing training, recruitment checks and supervision. We reviewed a variety of records relating to the management of the service, including policies and procedures 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 the last inspection this key question was rated as good. 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

- People were not protected from the risk of abuse. Staff had not followed procedures to ensure the safety of people and not all staff had received training on safeguarding.
- Staff we spoke with could not always demonstrate an understanding of the risks of abuse and the different ways to report concerns.
- During the inspection we were made aware of two incidents where people had been harmed and safeguarding procedures had not been followed. We raised alerts with the local authority, who are investigating the concerns. Prior to the inspection we had been made aware of previous safeguarding incidents that had not always been reported to the local authority or to CQC.
- People did not always receive their care call visits. Prior to the inspection, we received a number of concerns about missed calls and we had also been made aware by the local authority that there had been a safeguarding investigation into missed calls. People and their relatives told us staff often turned up late to calls or did not turn up at all. Relatives told us they were unable to speak to anyone to report the missed calls as no-one answered the phone.
- During the inspection we were informed of one day in January 2021 where the service missed 15 care visits.

The provider had failed to operate effective systems to prevent the abuse of service users. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- People were not always supported by staff who had undergone the necessary, legal checks to ensure they were suitable to work with people who may be vulnerable.
- Information supplied to us demonstrated there were several staff providing support to people who did not have up to date DBS checks obtained by the service. A DBS check helps to prevent unsuitable people from working with vulnerable groups by checking police records and barred lists. We also found the provider had not always obtained suitable references to be reassured staff were of good character.
- We found one staff member had previously had series of allegations of poor care and theft made against them at the service and had undergone investigatory and disciplinary procedures. We found this staff member was currently providing support to people and we did not find evidence of any risk assessment or risk management plans in place to ensure this person was monitored. Further allegations about this staff member's conduct was raised by a family member during the inspection.

The provider had failed to operate safe recruitment procedures to comply with legal requirements. This was a breach of regulation 19 (Fit and proper persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had failed to ensure all staff received appropriate training and supervision as was necessary to enable them to carry out the duties they are employed to perform.
● Information supplied to us during the inspection demonstrated there were large gaps in staff training and not all staff had undergone the required training prior to supporting people in the community. The training schedule involved 13 training courses delivered by power point in one session and some staff we spoke with told us they did not feel this was sufficient to safely provide care.
● At the time of the inspection, the care co-ordinator had been tasked to deliver the full training schedule; however, they were not qualified to deliver training, which included first aid and moving and handling of people. This placed people at risk of harm. No competency checks had been carried out to ensure staff were able to provide safe and effective care. No new staff were enrolled on the care certificate. The care certificate is a set of minimum standards for staff to achieve as part of a robust induction programme.

The provider had failed to ensure suitably qualified and competent staff had been employed and this was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Preventing and controlling infection
● The service had not always assessed the individual risks to people's health and wellbeing.
● We found there were no Covid-19 risk assessments in place for the service. There were no Covid-19 risk assessments or risk management plans in place for staff or people who use the service.
● People's care plans did not always reflect people's current risks. We found one person's care plan contained a risk management plan for their risk of skin breakdown and this was to include repositioning charts. However, we found this management plan was not followed and the person was fully mobile and did not require a risk management plan.
● Some staff we spoke with told us they had little or no training in safe infection control procedures to minimise the risk of cross infection. Not all staff told us they had received guidance on how to safely use personal protective equipment (PPE). One staff member told us they were only allocated one mask per day. Another staff member, who had tested positive for Covid-19, told us they had been directed to carry on supporting people, but to wear two masks and two pairs of gloves. However, they refused and isolated as required.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate risks were effectively managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Staff had not always followed procedures to ensure medicines were administered as prescribed or reported concerns about potential administration errors.
● Staff told us they had little or no training and did not always feel supported to safely administer medicines. Staff had not had their medicines competencies checked. One staff member told us they had previously been sent to support a person with their tracheostomy breathing tube, but had not had any training on how to do this and had to be guided over the telephone.
● We found one person's medicine administration record (MAR) had only partially been completed. On review of their records, it was unclear whether the person or staff members were administering medicines

and it was not recorded in care plans. We saw it was recorded in daily notes the person had taken their own medicines prior to one care visit, but it was recorded on the MAR that staff had administered the medicines. There were no audits of MARs completed.

● One relative told us there were days when they visited their relative and found tablets had not been administered and still in their blister pack. They told us when they had checked the safe, where the medicines were kept, they had found old blister packs with several tablets still inside. They had not been informed as to why this had happened. Another relative told us they often had to administer medicines to their relative due to staff turning up too late and there have been mistakes where staff had given night time medicines in the morning.

We found no evidence that people had been harmed however, the provider had not ensured medicines were safely managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● Robust systems were not in place to ensure learning occurred when things went wrong.

● Records demonstrated accidents and incidents were not routinely recorded. Nothing had been recorded since July 2018; this meant there was a lack of investigation and learning to prevent future events.

● Safeguarding investigations had not been recorded and there were no improvement plans to minimise the risk of reoccurrence of safeguarding incidents.

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 good. 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

- There was no managerial oversight or scrutiny of the quality of care and this was demonstrated in the multiple breaches of regulation identified on inspection.
- The service had not had a registered manager in place since September 2020.
- There was no management structure in place at the service and the service had been without any manager in post for six weeks prior to the inspection. We were informed a new manager would be commencing in post in February 2021.
- The provider had asked a care assistant, who had been in post for five weeks, and had no previous experience of care, to act as care co-ordinator for the service. At the time of the inspection the service had been run by the care co-ordinator for six weeks who had no experience care management. They had been tasked by the provider to complete training, competency checks and managerial responsibilities; however, they did not hold management or training qualifications or have any experience. There were no support mechanisms in place for the care co-ordinator; however, they had requested the assistance of a family member to come into the office and help out as the office assistant. We were subsequently informed by the provider the office assistant was employed as an office manager and the care co-ordinator was also employed as a field supervisor.
- The care co-ordinator and office assistant did not have any knowledge of regulatory requirements or the wider legal obligations of a service provider.

The provider had failed to ensure robust and effective management oversight of the service which had resulted in widespread and significant shortfalls. This was a breach of regulation 17 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; Continuous learning and improving care

- We found the service did not always report incidents of missed calls or send safeguarding alerts to the local authority in line with their policy. We saw no evidence where internal investigations had taken place into the reasons for the missed calls; nor where people had received an apology or reassurances of improvements in the level of care.
- There were no governance and monitoring systems in place that were being used to monitor the effectiveness and safety of the service.

● The provider had not ensured systems were in place to ensure people received their care visits as necessary, and not ensured staff were trained and competent to provide safe and effective care.
● We found no evidence of learning from past incidents. Accidents and incidents were not recorded and analysed to prevent further occurrences. Complaints had not been logged since June 2020; however, people's relatives told us they had complained about the service.

The provider had failed to implement robust and effective governance systems to ensure the safety, quality and continuous improvement of the service. This was a breach of regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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; Working in partnership with others
● We did not see any evidence that people were consulted with regarding the quality of the care they received. We were informed there were no mechanisms in place for gathering people's feedback on the quality of care delivery. No quality control calls were made to people. Relatives told us they often could not speak to anyone about care delivery as often no-one would answer the telephone.
● Care was not inclusive and person-centred. Relatives of people we spoke with told us their relative did not receive their care as they would like. They told us they did not receive continuity of care from regular staff members and staff would often be late or not turn up at all. One relative told us they had ten different staff members, several of whom were new starters, visit in one week and this had been confusing for their family member. Another relative told us often only one staff member will turn up to a call when there should be two and this meant the relative had to assist with moving and handling their relative or they had to administer medication when staff came too late.
● Some staff we spoke with told us they did not feel supported in their role and did not feel they could raise concerns and be listened to. There was no system to facilitate remote team meetings and staff had not received supervision and appraisal to enable them to feedback and discuss any concerns or suggest improvements to the service.

The provider had failed to seek and act on feedback people, staff or other stakeholders to evaluate and improve the service. This was 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

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 had failed to ensure the safe management of medicines and people's individual risks had not been assessed and managed.

The enforcement action we took:

We issued an urgent Notice of Decision to impose conditions.
The registration of this service was cancelled by CQC.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure systems and processes were in place to safeguard people from the risk of abuse. The provider had failed to ensure people always received their care visits and therefore, placed people at the risk of harm.

The enforcement action we took:

We issued an urgent Notice of Decision to impose conditions.
The registration of this service was cancelled by CQC.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). The provider failed to ensure there was sufficient management and oversight of the service to ensure the safe care and treatment of people.

The enforcement action we took:

We issued an urgent Notice of Decision to impose conditions.

The registration of this service was cancelled by CQC.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure they operated robust recruitment procedures to ensure all staff employed were suitable to work with people who may be vulnerable.

The enforcement action we took:

We issued an urgent Notice of Decision to impose conditions.
The registration of this service was cancelled by CQC.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to provide such appropriate support, training, professional development, supervision and appraisal as is necessary to enable staff to carry out the duties they are employed to perform.

The enforcement action we took:

We issued an urgent Notice of Decision to impose conditions.
The registration of this service was cancelled by CQC.