Hidmat Care Limited

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Inspection report

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Date of inspection visit:
20 April 2021

Date of publication:
01 June 2021

Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Hidmat Care Limited is a domiciliary care agency. It provides care for people living in their own houses and flats. People are supported in their own homes so that they can live as independently as possible. CQC regulates the personal care and support. There were 30 people using this service at the time of our visit.

People's experience of using this service and what we found
At our previous inspection we found that care records did not contain sufficient information and guidance to enable staff to support people in a safe way. At this inspection, we found that some improvements had been made to care planning and risk management systems, but further improvement was still needed.

People's safety was not always ensured because risk management was not always in place for falls, pressure area care, catheter care, diabetes management.

At the last inspection we found the provider did not always follow their recruitment policies and procedures to ensure staff were recruited safely. At this inspection we found some improvements had been made but there were still several staff employment references which had not been obtained. Improvements had been made with staff training records but staff were not always fully trained to provide effective care.

Improvements had been made within medicines management, recording and regular auditing of medicines was taking place. However, there was further work to do on medicine which was prescribed to use 'as required'.

We found that staff communication had improved and spot checks were beginning to take place to ensure staff they were competent in their roles.

Accidents and incidents were analysed and action taken where necessary.

Rating at last inspection
The last rating for this service was Requires Improvement (published 12 November 2020). There were breaches in Regulation 12 (Safe Care and Treatment) and Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that sufficient improvements had not been made and therefore they remain in breach of these regulations.

Why we inspected
CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hidmat Care Limited on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service until we 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? Inspected but not rated.	**Inspected but not rated**
Is the service well-led? Inspected but not rated.	**Inspected but not rated**

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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.

Inspection team
The inspection team consisted of two inspectors on site.

This service is a domiciliary care agency. It provides personal care to people living in their own homes.

Notice of inspection
We gave the service 24 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.

The inspection took place on 20 April 2021.

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.

The provider was 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.

During the inspection
We spoke with the registered manager and reviewed a range of records. We looked at the concerns and action the provider was requested to take in the Warning Notice.

We reviewed a range of records. This included six people's care records and multiple medicines records. We

looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, policies and procedures.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question, we had specific concerns about. We will assess all of the key question at the next comprehensive inspection of the service.

At our last inspection (published November 2020) the provider had failed to robustly assess the risk related to the health, safety and welfare of people. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This inspection was a follow up on a warning notice and we found that although some improvements had been made, there was not enough consistent improvement, this meant that the provider remained in breach of Regulation 12.

Assessing risk, safety monitoring and management

● At our last inspection, we identified issues with risk management. The lack of effective action to manage risks had put people at risk of harm.

●At this inspection, we found that some improvements had been made to risk assessments and risk had been mitigated in some areas. However, there were some areas which required further improvement as this was not consistent. We found that some people who had known risks did not have the appropriate risk assessments in place. This included people with known mobility concerns, skin integrity issues or people who were at risk of falls This put people at risk of not having health conditions monitored or referred on to professionals where necessary.

●There were records of staffs' individual care induction and training, however, staff were not trained in specific care tasks such as pressure area care, dementia and diabetes. This meant that staff may not be competent to work with people who had those conditions.

The failure to provide safe care and treatment was an ongoing breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspected but not rated

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 Inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question, we had specific concerns about.

We will assess all of the key questions at the next comprehensive inspection of the service.

At our last previous inspection (published 12 November 2020) the provider had failed to ensure there was effective systems and processes to monitor and improve the quality of the service. This was a breach of regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This inspection was a follow up on a warning notice and we found that although some improvements had been made, there was not enough consistent improvement, this means that the provider remains in breach of Regulation 17.

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

- Systems and processes to assess, monitor and review quality, safety and risk had improved since our last inspection but required further work to ensure that all risk was assessed to keep people safe.
- Audits on records were being carried out by the registered manager and as the daily notes were kept on an electronic system, they had good oversight of the visits made. Management spot checks were carried out on staff when they provided people's care, but needed to be more frequent.
- Care records were reviewed on a regular basis and were current, however, not all care plans had appropriate risk assessments which required further work. There had been improvement around guidance around conditions and risk management, but further improvement was needed. The care manager told us that they would be reviewing the files and putting systems in place to improve consistency and quality of the information.
- Management spot checks on staff practice and arrangements for their supervision and appraisal had improved. However, this still needed to be carried out more frequently to ensure staff were carrying out their role effectively and people were kept safe..
- At our last inspection we found that staff were not recruited safely. At this inspection, we found improvements had been made, however, not all staff had two references prior to starting in post, the registered manager told us that this would be rectified. Other pre employment checks had been carried out such as checking criminal records and proof of ID were all in place.
- At our last inspection we found that not all staff had received up to date relevant training. At this inspection we saw they had developed a staff training matrix which was kept updated. Most staff were up to date with mandatory training. However, training on specific conditions had not been undertaken and the registered manager told us that this was being addressed and they were going to include training on specific

health conditions such as diabetes and dementia. Moving and handling training was carried out in the office, however, there was no bed for staff to practise with.

The failure to provide effective management oversight is an ongoing breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the last inspection we found that we were not assured that medicines were managed safely. Staff medicine competencies were out of date and there were errors in recording medicines. We saw that staff had received recent training and were assessed as competent.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● At our last inspection we found that the provider conducted surveys of people's views, however this information had not been analysed, used or fed back to staff to inform any resulting improvement needed.
● At this inspection we found that this remained the same and information was still not being analysed. It is important that the registered manager looks through the information to identify any themes or trends to make any improvements identified.
● The registered manager had started a group chat where they could communicate with staff and staff could ask for help or advice. This kept staff informed, and they could also request support and advice through the group chat. The provider had introduced an electronic staff communication and care call system, to further ensure the safety and timeliness of people's care.

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 Failure to effectively assess and mitigate risk and ensure health and safety checks and systems were in place put people at risk of harm.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Failure to ensure quality assurance processes effectively identified shortfalls in a timely manner in line with policy and procedures put people at risk of harm.