Hidmat Care Limited

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Inspection report

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Date of inspection visit:
06 October 2020

Date of publication:
13 November 2020

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Hidmat is a domiciliary care agency, providing personal care to 31 people at the time of the inspection.

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
Care records did not contain sufficient information and guidance to enable staff to support people in a safe way. Risk management was not always in place for falls, pressure area care, catheter care, diabetes management and the use of oxygen.

The provider did not always follow its recruitment policies and procedures to ensure staff were recruited safely.

It was unclear if staff had received adequate training for their roles. The training records were out of date and there were gaps in some staff training records.

There were no recent audit of medicines management and some staff competencies in medicines were out of date.

Some staff training in infection control and prevention was out of date

The service had sufficient numbers of staff, but there was a lack of supervision and spot checks on staff performance.

Governance arrangements did not provide assurance that the service was well-led. The provider had not ensured that their systems and processes to monitor the quality of care was effective. The provider had not ensured the service had a registered manager in place.

There was a lack of analysis of incidents and it was not clear that lessons were learned, and improvements were made when things went wrong.

Positive feed-back was received from people and their relatives about the service and its staff. Staff were positive about the service and the support from the management team.

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

Rating at last inspection (and update)

The last rating for this service was Requires Improvement (published 21 July 2019) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made or sustained and the provider was still in breach of regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
We received concerns in relation to recruitment processes and incident management. 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 remained requires improvement. This is based on the findings at this inspection.
We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this report.

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

During the inspection the manager took immediate steps to address our concerns and make immediate improvements.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hidmat Care Ltd 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 monitor the service.

We have identified breaches in relation to poor risk assessment and a lack of quality monitoring of the service.

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

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.

Since the last inspection we recognised that the provider had failed to ensure there is a registered manager in place at the service. This was a breach of regulation. Full information about CQC's regulatory response to this is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good.

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?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Hidmat Care Limited

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. An assistant inspector and an expert by experience were off site making phone calls to staff and service users. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service

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 48 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 activity started on 5 October 2020 and ended on 6 October 2020. We visited the office location on 6 October 2020.

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. We contacted Healthwatch. 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. We used all of this information to plan our inspection.

During the inspection-
We spoke with 10 people who used the service and four relatives about their experience of the care provided. We spoke with ten members of staff including the manager, senior care workers, and care workers.

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

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 an increased risk that people could be harmed.

At our last inspection 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.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

Assessing risk, safety monitoring and management

- Risk assessment were not always in place and people's needs were not always fully and effectively assessed.
- There was a lack of formal assessment tools in use and staff were unclear on the risks posed to people using the service.
- For example, one person had no risk assessment for catheter care. Another person had no risk assessment regarding the risk of pressure sores.
- People who had health conditions such as diabetes and epilepsy did not have risk assessments in the event of low or high blood sugar or seizure. It was not clear if staff had training in how to support these needs and there was insufficient guidance in place for staff to follow.
- Staff we spoke with could not always identify what they would do in the event of a deterioration in conditions such as diabetes. This posed a risk to people using the service, as staff were unable to support their needs without clear training and guidance in place.
- We identified the issue of risk management at our previous inspection. The lack of effective action to manage risks has put people at risk of harm.

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

The manager told us following our inspection they had booked training in risk assessment for the management team.

Learning lessons when things go wrong

- The service did not always learn lessons when things went wrong as systems and processes to review and analyse incidents, accidents and medicines errors were ineffective.

●The manager told us there were no incidents, accidents or near misses recorded for us to review.
●However, staff and service users gave us examples of incidents and accidents that had not been recorded.
●For example, one person had fallen recently. Another person had sustained an injury to their legs, these were not recorded on an incident form.
●A medicine chart we reviewed showed a medicines error which had not been reported.
●Therefore, the opportunity to prevent reoccurrence, learn lessons and improve the service were missed.

Staffing and recruitment
●There was a lack of robust recruitment processes in place and the service was not following its policies. For example, records of staff interviews were not in place. Not all staff had the required references in place.
●This means the provider could not be assured that staff recruited were suitable for the role.
●There were no records of induction, probation or shadow shifts for new staff.
●Spot checks, supervision and appraisals were not performed on a regular basis. This meant that staff performance was not monitored adequately to ensure that poor performance was addressed.
●Staff told us the training was good, and the provider had recently implemented new electronic learning resources. However, the training matrix we saw was out of date and did not reflect all the training staff had received.
● Staff had gaps in their training records, and there was a lack of training recorded in health needs such as epilepsy, diabetes, catheter care, and mental capacity assessment.
●One person told us, "They know what they are doing and always check if I want anything else".
●Staffing levels were safe. People told us there were enough staff, they arrived on time or notified them if they were running late.

Using medicines safely
●We could not be sure that medicines were always managed safely.
●A large number of staff had medicines competencies that were out of date.
●There was a lack regular medicines audits to identify errors.
●People told us they thought their medicines were given safely, but due to the concerns of out of date medicines competencies, we were not assured staff were suitably skilled to support people's medicines administration

The manager told us following our inspection that they were updating medicines training and competencies immediately.

Preventing and controlling infection
●We were not assured that the provider had taken enough measures to ensure staff had sufficient training and information about Covid-19.
●The management team had not assessed the risk levels of service users in relation to Covid-19.
●A large amount of staff training in preventing the spread of infection was out of date. Therefore, we could not be assured that staff had the skills they needed to keep people safe.
●We have also signposted the provider to resources to develop their approach

The manager told us following our inspection that they were updating the infection control training immediately.

Systems and processes to safeguard people from the risk of abuse
●We could not be sure that there were effective systems and processes in place to safeguard people from

the risk of harm.

●Staff we spoke with could identify signs of abuse and told us how they would report it, however staff knowledge of whistleblowing was limited. Due to the lack of incident reporting at the service, we could not be sure that the service was identifying all events that should be reported to the safeguarding team.

●The management team knew their responsibility to report incidents to the safeguarding team.

●People told us they felt safe. They knew the staff who were coming, and they thought the staff were well trained and knew what they were doing.

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 requires improvement. At this inspection this key question has deteriorated to Inadequate. 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.

At our last inspection 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.

Not enough improvement had been made at this inspection and the provider was still 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 were ineffective. This is an ongoing concern from our previous inspection and actions had not been taken to improve this.
- There was no registered manager in post during the inspection and the service had not had a registered manager for over a year.
- Audits were ineffective. Audits of care records were not up to date and had not been performed regularly. The last medicines audit was performed six months previously and had not been analysed.
- The management team were not performing regular supervision, spot checks or appraisals on staff in line with their policies. We could not be sure that staff performance was monitored regularly, and that staff had the skills, experience or competency required.
- There had been no staff meetings for over six months and there were no records of staff meetings available for us to review.
- Care records were not reviewed on a regular basis and some contained out of date information. Guidance around conditions and risk management was not always present.
- Staff had an app on their phones to log in and out and although the management team had daily oversight of this, they did not analyse late calls to identify areas of improvement. One member of staff did not use the app when they attended people, so these were recorded as missed calls.
- There was a lack of continuous learning. The service did not analyse incidents and accidents in order to identify themes and trends to improve care.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate monitoring of quality processes were effectively managed. This placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance) 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

●People were positive about the care they received, and staff were very positive about the support they received from the management team.

●People told us the management team were responsive to concerns. One person told us," I don't have any complaints and if I did the office would sort it". Another told us, "The management team are fantastic".

●One person told us how the service supported him when he was unwell and stayed with him for hours until an ambulance arrived.

●Care plans had been improved and were person centred, so we could see people had been involved in writing them.

●People told us staff arrived on time or contacted them if they were running late and they got regular carers. One person told us, "I am happy, no problems and I don't worry about who is coming".

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

●The provider conducted surveys of people's views, however this information had not been analysed or fed back to staff.

●The provider had not completed any staff surveys for over a year.

●Staff meetings had been impacted by Covid-19 and there had been no staff meetings recorded since December 2019.

●There was no evidence of how the service improved following feedback from staff or service users.

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 manager understood duty of candour and could give an example of a recent event where a medicine was missed, and the person was informed. However, there was no evidence of this recorded.

Working in partnership with others

●The provider worked in partnership with external agencies, such as healthcare professionals and the local authority to coordinate people's care.

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 Failure to effectively assess and mitigate risk and ensure health and safety checks and systems were in place and have robust medication, infection control and recruitment procedures in place put people at risk of harm. Regulation 12 (1) (2) a, b, c, h

The enforcement action we took:

Warning notice.

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. Regulation 17 (1) (2) a, b, c, d, e, f

The enforcement action we took:

Warning notice.