HLC Care agency Ltd

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Inspection report

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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
HLC Care Agency Ltd is a domiciliary care home service providing personal care to 11 people at the time of the inspection. Most of the people who used the service were older people. Everyone who used the service received personal care. The 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.

People's experience of using this service and what we found
Care plans contained some risk assessments which were appropriately linked to their support needs. However, risks were not consistently assessed and there was still a lack of information for staff about how to support people to remain safe.

Staff were trained with the right skills and knowledge to provide people with the care and assistance they needed. However, the training programme did not contain any provision for Parkinson's disease, which was relevant to the people supported.

The provider did not have an effective system in place to assess, monitor and improve the quality and safety of the services provided.

Since our last inspection, the provider had ensured that medicines were managed safely or in line with best practice.

Staff felt there was an open culture where they were kept informed about any changes to their role. Staff told us the registered manager was approachable and listened to their ideas and suggestions.

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 rating at the last inspection was Inadequate (published 9 January 2020) 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 we found the provider had improved the service by ensuring that medicines were managed safely. However, the provider requires further improvement in risk assessment, care related guidance, effective quality auditing and contemporaneous record keeping.

Why we inspected
We undertook this targeted inspection to check whether the Warning Notices we previously served in relation to regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. The overall rating for the service has not changed following this targeted inspection and remains Inadequate.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at the 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 the key question.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of 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.

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 overall rating for this service is 'Inadequate' and the service remains 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?

Inspected but not rated

At our last inspection we rated this key question Inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question Inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

HLC Care Agency 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.

This was a targeted inspection to check whether the provider had met the requirements of the Warning Notice in relation to Regulation 12 Safe care and treatment and Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspection team
The inspection was carried out by two inspectors, one of whom attended the service and one who worked offsite.

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

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

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. Inspection activity started on 24 August and ended on 26 August 2020. We visited the office location on 25 August 2020.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We received feedback from a local authority who commission 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 used all of this information to plan our inspection.

During the inspection
We spoke with one person who used the service and five relatives about their experience of the care provided. We spoke with five members of staff including the registered manager.

We reviewed a range of records. This included multiple medication records, risk assessments, training and quality records. A variety of records relating to the management of the service were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at care related management plans, care related guidance documents and 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 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.

The purpose of this inspection was to check if the provider had met the requirements of the Warning Notice we previously served about safe care and treatment. We will assess all of the key question at the next comprehensive inspection of the service.

At the last inspection in October 2019 the provider had not ensured medicines were managed safely. The provider had failed to ensure that risks to people were always assessed. The provider had failed to ensure that there were appropriate risk assessments in place. These were breaches of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found the provider had improved the service by ensuring that medicines were managed safely. However, the provider had not fully ensured that there were appropriate risk assessments in place. The provider requires further improvement in risk assessments and specialised training for staff in the provision of safe care.

Not enough improvement had been made at this inspection and the provider was still in breach of regulations 12 and had not fully met the requirements of the warning notice.

Assessing risk, safety monitoring and management

- Risks were not consistently assessed and there was still a lack of information for staff about how to support people to remain safe. For example, out of the four support plans we looked at, two people had a diagnosis of Parkinson's disease. Staff had not been adequately trained to know and understand how Parkinson's disease affects people and how they could effectively support people.
- The provider had 'Vascular dementia and Parkinson's risk assessment' together as one risk assessment. The risk assessment failed to differentiate between dementia and Parkinson's disease. Alzheimer's disease affects language and memory, while Parkinson's disease affects problem solving (executive function), speed of thinking, memory and other cognitive functions, as well as mood. This meant that care staff would be unable to identify signs and symptoms of each diagnosis.
- Other risks, for example around choking had not been assessed. One person's eating and drinking plan included a recommendation from a speech and language therapist and noted, 'To be supervised at all times with eating and drinking due to their compulsive fast rate of oral intake which resulted in previous signs of aspiration, coughing and post swallow'. There was no guidance for staff about how to keep this person safe and what action to take if they began to choke. There was no detailed aspiration or choking risk assessment in place. This meant that the person was at risk of choking when eating.
- After the inspection, the provider sent us an NHS choking risk assessment which they planned to implement. We will review this at our next inspection.

● Since the last inspection, care related risk assessments and guidance for areas such as diabetes, continence and catheter care had been put in place. Other risk assessments specific to each person were in place and had been reviewed when required. For example, people who used equipment to help them mobilise or transfer had been appropriately assessed to evidence safe systems of work for the staff to follow.
● Black Asian Minority Ethnic risk assessments had been implemented according to government guidance on COVID-19.
● COVID-19 risk assessments had been implemented for all the people using the service and staff according to government guidance.

We found no evidence that people had been harmed however, appropriate risk assessment were not fully in place. This placed people at risk of harm. This was a continued breach of regulations 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● A relative commented, "The carers give [my loved one] their medicines and we haven't had any problems with that".
● Medicines administration records had been implemented. Staff recorded each time medicines were given or prompted.
● All the staff we spoke with told us they had completed medicines management training and had their competency assessed. We viewed records which confirmed the registered manager had taken steps to ensure staff practice was safe.
● Staff were knowledgeable about people's medicines, including 'as and when' medicines, such as pain relief, and understood how to report any concerns.
● There were up to date policies and procedures in place. This included guidance documents from National Institute for Health and Care Excellence for managing medicines for adults receiving social care in the community.

Preventing and controlling infection
● Staff completed regular training about infection prevention and control. Staff told us they wore the correct personal protective equipment (PPE). They had access to stock of PPE when needed.
● There were effective systems in place to reduce the risk and spread of infection.
● PPE, such as gloves, mask and aprons, were used by staff to protect themselves and the person from the risk of infection and COVID-19. Staff were also issued with hand gel.
● Staff were trained in infection control. A member of staff said, "I have done NVQ3. We completed training infection control, COVID-19 and how to use and take off PPE."

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 have specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served about good governance. We will assess all of the key question at the next comprehensive inspection of the service.

At the last inspection in October 2019 the provider had not ensured they had sufficient oversight of the service and standards of care to enable them to monitor and improve the quality of the services provided. This was a breach of regulation 17 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 and had not met the requirements of the warning notice.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.

- There continued to be no effective systems in place to check the quality of the service including reviewing care plans, incidents, daily records and risk assessments.
- We spoke with the registered manager to ask whether there were any records of audits and checks to evidence that they were monitoring the service and they showed us their diary that contained diarised information and not a comprehensive audit. This meant that the registered manager did not have a robust system in place for monitoring the quality of the service.
- The registered manager's diarised entries had not been effective in identifying the concerns we found during this inspection. Robust audit systems would have improved the quality of the service provided by the registered manager by highlighting the issues we found.
- Some records relating to the care and support of people were ineffective. Two people who had Parkinson's disease had no specific Parkinson's disease guidance for staff, which would have explained how the disease affected each person individually and what signs they should look out for if the person relapsed to keep the person safe. This was not reflected in people's care plans. In another person's care plan, a speech and language therapist had recommended to be prompted to have small single sips and small bites, guiding her hand to physically prompt her when eating and drinking to control oral intakes and avoid high risk food items. We found no further guidance for staff. The daily log failed to evidence this was being followed by staff. This meant that the service failed to maintain complete and accurate records for people, which would have further enabled staff to provide safe care.
- The provider had sufficient oversight into staff performance and practice. Spot checks were now being completed and were effective in monitoring, auditing of staff timekeeping or call length.

We found no evidence that people had been harmed however, the above issues showed that the provider had failed to ensure robust quality assurance and monitoring systems were in place to identify the shortfalls we found and act on them appropriately. This was a continued breach of regulations 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 did not understand the responsibilities of their registration. Registered bodies are required to notify the Care Quality Commission (CQC) of specific incidents relating to the service. We found that notifications had not been sent to us appropriately. For example, in relation to any serious incidents concerning people which had resulted in an injury or any safeguarding concerns. During the inspection, we identified an alleged incident of neglect, which was not reported to CQC. We spoke with the provider about this and they told us that it was dealt with hence they did not report it or raise a safeguarding alert to the local authority.

● It is a legal requirement that the latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had clearly displayed their rating at the office and on their website.

Failure to notify CQC of a serious incident was a breach of Regulation 18 (Notification of other incidents) Care Quality Commission (Registration) Regulations 2009.

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

● People and relatives had mixed views about the management of the service. Comments included, "If I was worried about something, I would ring the office. I have met the manager once, when they did an assessment with [my loved one] at the beginning" and, "I am not confident in the management."

● Staff felt confident in the management of the service. They told us, "The manager is very approachable and very supportive. The manager is dependable. They definitely listen to you and make you feel valued", "HLC is a good place to work. I am really impressed with the manager. They show us encouragement. Throughout the pandemic they have sent us regular messages. This makes us happy" and "The manager does listen to us. If I have a problem or worry about a client, we talk about it and look at what we can do to help. Suggestions are listened to".

● Communication within the service continued to be facilitated through monthly team meetings. A member of staff said, "We have normal team meetings and we are asked to add to the agenda. We discuss policies, performance issues and we can raise anything we want to. Our meetings are inclusive. We also have regular meetings with the head of service and administrative staff."

● At our last inspection, we found that no surveys had been sent to health and social care professionals to seek their views of the service. At this inspection, this was still the same. However, the provider had systems in place to receive people's feedback about the service. The provider sent out 15 survey questionnaires to people using the service to gain feedback on the quality of the service; 10 people responded, and action had been taken. For example, it was noted people were not sure how to complain. The provider updated this information via a handbook which had been given to people. Other comments received from people included, "Carers look neat and tidy" and "People are informed when carers are running late."

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify CQC of a serious incident. This was a breach of Regulation 18 (Notification of other incidents) Care Quality Commission (Registration) Regulations 2009.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure appropriate risk assessment were in place. This placed people at risk of harm. This was a continued breach of regulations 12 (1)(2)(a)(b)(c) (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider failed to continuously operate effective systems and processes to assess, monitor and improve the quality and safety of the service. Failed to ensure records were accurate, complete and consistent and failed to act on feedback from previous inspection. This was a continued breach of Regulation

17(1)(2)(a)(b)(c)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.