Humble Healthcare Limited

Humble Healthcare Limited

Inspection report

Unit 9, Red Lion Court
Alexandra Road
Hounslow
Middlesex
TW3 1JS

Tel: 02085706279

Date of inspection visit:
05 October 2021

Date of publication:
12 November 2021

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Humble Healthcare Limited is a domiciliary care agency providing personal care and support to people living in their own homes. At the time of our inspection, 52 people were using the service.

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
People were not always safely cared for. Risks to their safety and wellbeing had not been assessed, planned for or monitored. Medicines were not always safely managed and the provider did not ensure support with financial transactions and shopping was assessed, monitored or recorded.

People did not always receive personalised care. Care plans gave basic information, and these were sometimes inaccurate and about other people.

The provider's systems for monitoring and improving the quality of the service were not always operated effectively. Records were not always accurate or complete and the provider had failed to identify this.

The provider did not always ensure sufficient numbers of suitable staff were deployed and they did not always operate their recruitment processes effectively.

Most people using the service and their relatives told us they liked their individual care workers, although some told us care was not delivered on time or care staff could not provide the care they wanted.

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

Rating at last inspection
The rating at the last inspection was good (published 23 November 2019).

Why we inspected
The inspection was prompted in part due to concerns received about medicines management and how the service managed risk, following two safeguarding alerts.

We carried out monitoring of the service by speaking with the registered manager and requesting certain documents on 2 September 2021. We were not assured that the standards of quality and safety were being met. As a result, we undertook a focused inspection to review the key questions of safe, responsive and well-led only.

We have found evidence that the provider needs to make improvements. Please see the safe, responsive 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 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.

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 requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Humble Healthcare 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 person-centred care, safe care and treatment, protecting service users from abuse, good governance, staffing and fit and proper persons employed at this inspection.

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

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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

Humble Healthcare 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 was conducted by one inspector. We were supported by an Expert by Experience who made phone calls to people using the service and their relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service had a manager registered with the Care Quality Commission. This means that they 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
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 29 September 2021 and ended on 8 October 2021. We visited the office location on 5 October 2021.

What we did before the inspection
We carried out a review of data and information about the service on 2 September 2021. This included a telephone interview with the registered manager. We also spoke with one person who used the service and the relatives of eight other people on 31 August 2021. We requested some records from the provider, but they did not share these with us.

We spoke with a representative of the safeguarding authority and they expressed concerns about the service.

We spoke with a further two people using the service and relatives of four other people on 29 September 2021.

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.

During the inspection
We visited the service on 5 October 2021 and met with the registered manager and a care coordinator. We asked to look at a sample of records but were told the computer system was not working and we were not able to view these. We requested named documents were sent to us as soon as the system was working again.

We looked at medicines administration records for four people, records of recruitment, training and support for five members of staff, records of quarterly quality monitoring, a selection of policies and records of two incidents. We were told no other records were available for us to view.

After the inspection
We reviewed care plans and risk assessments for 11 people who used the service, a further five staff members records, records of staff meetings and examples of positive feedback the provider had received. We requested additional medicines records and training records but were not provided with these.

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.
Assessing risk, safety monitoring and management
● Risks had not been properly assessed, were not monitored and the provider was unable to demonstrate these had been managed. Recorded risk assessments were a list of risks, had not been personalised and did not include any plans about how risks were mitigated or managed.
● The care coordinator described how one person who was supported to access the community could be aggressive towards others, often ran away from staff and required two members of staff to prevent them from harming themselves or others. Their care plan also described risks such as unpredictable behaviour, self-harm, violence towards others, choking and PICA (a type of eating disorder where a person eats non-food items). There were no plans to describe how to support the person with these needs, the risks had not been assessed and there were no plans to show how the risks were mitigated or managed.
● Other people's care plans included references to a range of health conditions, including diabetes (inability to control blood sugar levels), COPD (breathing difficulties), kidney infections and pressure wounds. There were no risk assessments or plans for any of these people. This meant staff did not have the information needed to keep people safe, to monitor and manage risks associated with these conditions.
● The care for one person included support in the community and driving the person long distances. There were no assessments or plans in relation to these activities or evidence staff had been assessed to make sure they were competent to provide this support.
● People's care plans included a range of physical needs, such as support to transfer from beds and chairs to standing, support with walking, use of the toilet, using hoists and walking aids and the risk of falling. There were no assessments or plans for people in relation to these risks.
● The provider's assessments of people's home environments were inaccurate and therefore risks had not been assessed or mitigated. For example, one person's records stated they lived in a single storey building but also referred to risks using the stairs. Therefore, the information could not be relied upon to be accurate. Seven people's environmental assessments were identical, stating there were risks relating to their beds, chairs, clutter and flooring. None of these risks had been assessed or planned for. There was no information about any potential fire safety risks or how to ensure people were safe within their home environment.

Failure to assess, monitor and manage risks 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
● People did not always receive their medicines safely and as prescribed. The records relating to medicines were not clear, accurate or detailed enough and the provider was not able to demonstrate they had assessed risks relating to medicines or trained and assessed staff competency.
● The registered manager initially told us that only four people were supported with their medicines. This was not the case and care plans, electronic monitoring and other records showed that others were

supported with medicines. There were no records relating to this to show that people had received their medicines safely and as prescribed, including no administration records and no details of the medicines people were prescribed.

● The registered manager showed us the medicines administration records for four people for July and August, and two people's September 2021 medicines administration records. For one person their personal details had not been completed. For two people there was no information about some of their medicines, including dose, time of administration or evidence these had been administered.

● One person's care plan and medicines record included information about a medicine which needed to be taken 30-60 minutes before any other food or medicines. There was no instructions for this to make sure it happened within the care tasks for the person and the medicines administration record showed this had been administered at the same time alongside other medicines.

● Records for eight people whose care we looked at stated the staff administered creams. There were no records to show where these should be administered, no other details to state what the creams were and no records to show these had been administered as prescribed.

● There were no risk assessments in relation to medicines or medicated creams to show potential risks had been assessed or planned for.

● The recorded medicines competency tests for staff were a checklist- style knowledge check and there was no evidence staff had been regular assessed supporting people with their medicines to make sure they were doing this safely and correctly.

Failure to safely manage medicines placed people at risk and was a further breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● The provider's systems and processes did not ensure people were protected from abuse. Two people whose care plans we viewed required support with shopping. There were no financial risk assessments, no records of how the support should be delivered and no record of support which had been provided, including financial transactions.

Failure to operate systems and processes to safeguard people from abuse was a breach of Regulation 13 (safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● The provider had a procedure for safeguarding adults. Staff had undertaken training in this.

Learning lessons when things go wrong

● The provider did not always ensure staff learnt from things that went wrong. There were two safeguarding alerts and investigations in 2021 which identified poor practice. The registered manager told us they had discussed lessons learnt with the staff following these, but this was not recorded and staff meeting minutes and supervision records did not show these concerns had been discussed.

Failure to effectively operate systems and processes to improve the quality of the service was a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment

● The systems for recruiting staff were not always operated effectively. Application forms for some staff referred to roles working in other care settings, although the provider had not sought references from these employers. Some information on application forms did not make sense, such as records of training in social

and healthcare without previous work in this field, one person stating they had been at school from the age of 24-27 years and additional employment histories to match references added to application forms in different handwriting. The provider had not followed up discrepancies at interview or as part of the recruitment procedures.

Failure to effectively operate systems and processes to safely recruit staff was a breach of Regulation 19 (fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● Records of reference checks, interviews, checks on staff identity, eligibility to work in the United Kingdom and any criminal records were in place.
● The provider had not always ensured staff were suitable because their inductions were not always thorough. For example, some staff without previous experience in the care sector had only undertaken a few hours shadowing experienced staff. There were no detailed competency checks. Some people had complex health needs and required support with these and medicines. The staff had not been trained to understand or meet these needs. This meant the provider had failed to deploy suitable staff to meet the needs of people using the service.

Failure to deploy suitable staff was a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people told us staff did not always arrive on time and were sometimes rushed, but most people said this was not a problem. The provider had an electronic call monitoring system and records we viewed showed that staff had arrived on time for care visits and stayed the correct amount of time.

Preventing and controlling infection
● The provider had systems to prevent and control infection. The staff had training in this area. The provider supplied enough personal protective equipment (PPE). People using the service and their relatives told us they used this.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Care was not always planned in a personalised way. Care plans were basic and did not included information about how people liked to be cared for or how to meet specific individual needs. There was hardly any personal information and care plans were mostly just a list of tasks, some of which did not apply to the person they were written about.
- The information in care plans was sometimes contradictory and was not always about the person. For example, some care plans referred to the wrong person's name, the wrong gender or gave different information about a particular need or ability.
- People's communication needs were not always planned for or met. The care plan for one person stated they were non-verbal. There was no guidance or information for staff about how they should support or communicate with this person.
- Care plans were not in an accessible format for people to understand. People did not know whether they had a care plan or not.

Failing to plan personalised care was a breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some people told us care workers did not always meet their needs and there was a lack of consistency in their care. However, most people and their relatives were happy with their regular carers and told us their needs were met. With comments which included, ''The carer is sweet and observant'' and ''They treat [person] well.''

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- The provider's care plans did not describe how to support people with maintaining relationships or leisure interests. However, some people commented they had good relationships with staff and enjoyed social interaction with them. One person was supported to access community activities.

Improving care quality in response to complaints or concerns

- The provider had a complaints procedure and people told us they knew who to speak with if they had any

concerns.

End of life care and support

● The provider had worked with people's families and specialist healthcare teams to provide support to people at the end of their lives when they needed this.

Requires Improvement

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 requires improvement. 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.

Continuous learning and improving care

● The provider did not always effectively operate systems and processes to assess, monitor and improve the quality of the service. Since the last inspection, some of the standards around record keeping had deteriorated, and the provider was not able to demonstrate they had always fully assessed and planned for people's needs.

● Systems and processes had not always effectively assessed, monitored or mitigated risks. For example medicines were not safely managed and risk assessments were not an assessment, but a statement of information (sometimes inaccurate) with no plan to manage the risks and no records to show these assessments were monitored or that action had been taken to mitigate risks.

● The registered manager was not able to give us clear or accurate information. For example, they told us four people were supported with medicines, although records indicated more people were. When we asked the registered manager about one of these people, they told us they had forgotten that person had support with medicines but were still unable to show us any records relating to this.

● Risk assessments and care plans for different people were identical and information had been copied and pasted from other people's records. This meant they were not accurate and could not be relied upon.

● The provider did not always follow their own systems and processes to ensure staff were suitable and had the skills and competencies to care for people.

● The registered manager showed us copies of ''quarterly monitoring'' surveys with people and/or their families. These were identical, did not include any personalised feedback or comments, were written in the same handwriting and were not dated. Furthermore, there was no analysis of the responses.

Failure to effectively implement systems and processes to assess, monitor and improve the quality of the service, and assess, monitor and mitigate risks was a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager had sourced a consultant who supported them to assess and monitor the quality of the service. They regularly met with them to review whether improvements were needed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Some people felt unhappy with the care they had received with one person telling us care workers ''moaned'' about their personal lives to them and others telling us care workers were sometimes late or

rushed. However, most people and their relatives were happy with the service and felt their needs were met. Some of their comments included, ''They are wonderful and know me well'', ''My carer is good'' and ''The care staff give me time, are helpful and reliable.''

● The provider showed us positive comments and reviews from 15 different people which they had received in the past six months, describing how people were happy with the service, especially their regular care workers.

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 had procedures for dealing with complaints, adverse events and duty of candour. They had submitted notifications to CQC regarding significant incidents and safeguarding alerts.

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

● The registered manager was also the owner of the company and had a good knowledge of people using the service. People and their relatives felt they could contact them and would get a response when needed.

● The provider sourced a consultant who had helped them to ensure policies and procedures met the requirements of regulation and good practice.

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

● People told us they had regular contact with the registered manager, although their opinions and views were not always reflected in care plans. People told us staff could speak a variety of languages and this was helpful with communication and meeting cultural needs.

Working in partnership with others

● The provider was involved with local community groups and worked with other providers to share information and support.

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 9 HSCA RA Regulations 2014 Person-centred care The registered person did not always ensure service users received personalised care which met their needs and reflected their preferences. Regulation 9

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person did not always effectively operate systems and processes to protect service users from abuse. Regulation 13

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person did not always effectively operate recruitment procedures. Regulation 19

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person did not always deploy enough suitably qualified and experienced staff to meet the needs of service users.

Regulation 18

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 registered persons did not always ensure the safe care and treatment of service users. Regulation 12

The enforcement action we took:

We have issued a warning notice telling the registered person they must make improvements by 30 November 2021.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not always effectively operate systems and processes to assess, monitor and improve the quality of the service. Regulation 17

The enforcement action we took:

We have issued a warning notice telling the registered persons they must make improvements by 30 November 2021