Aquaflo Care Ltd

AQUAFLO CARE LIMITED

Inspection report

Units 2,3,4 & Ground Floor
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London
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13 June 2017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 8 and 13 June 2017 and was announced.

At our previous inspection on 31 January, 1 and 2 February 2017 continued breaches of legal requirements were found. The provider was issued with three warning notices in relation to safe care and treatment, complaints and notification of incidents. The warning notices asked the provider to make improvements within a limited period of time.

We undertook this focussed inspection to check that they now met the legal requirements in relation to the warning notices. This report only covers our findings in relation to this requirement. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'AQUAFLO CARE LIMITED' on our website at www.cqc.org.uk' At this inspection, we found that the provider had made improvements but these were still in progress in relation to the requirements in one warning notice and therefore this had not yet been fully met.

AQUAFLO CARE LIMITED is a domiciliary care agency which provides personal care and support to people in their own homes. At the time of our previous inspection the service was providing support to 132 people in the London Boroughs of Hackney, Tower Hamlets and Islington. The majority of the people using the service were either funded by the local authority or the NHS. At this inspection they were supporting 135 people.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Appropriate policies and procedures were not always in place to ensure that people received their medicines safely and effectively. People's records had been updated and now included more detailed information about the medicines they took and the support they received. However, medicines records were not always being checked appropriately to ensure people received them safely. The return and auditing of medicines records was still being implemented at the time of the inspection.

People who lived with specific health conditions had been assessed and their risk assessments had been updated, to highlight the risks associated with these conditions. It included guidance for care workers on how manage these risks. However there were inconsistencies in the care records viewed and not all people's care plans reflected the current level of care being provided.

Improvements had been made in how the provider dealt with people's complaints and we saw that complaints viewed at the previous inspection had now been investigated and followed up. Learning had taken place since the previous inspection and shortfalls in customer service had been acknowledged and action taken.

The provider had made some improvements regarding notifying the Care Quality Commission (CQC) of serious incidents which they have a legal obligation to do so. Statutory notifications had been received since the previous inspection, recorded and followed up appropriately.

We found one continuing breach of regulations relating to safe care and treatment and asked the provider to submit an action plan to tell us how they were going to make the necessary improvements. We also asked the provider to send us specific documents about people's care to show us what improvements they had made since the inspection was completed.

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.

Despite some improvements being made, appropriate policies and procedures were not always in place to ensure people received their medicines safely and effectively.

Risk assessments had been updated with more detailed information provided but there were inconsistencies in the records we reviewed. People's records did not always reflect the current level of care being provided.

We were unable to change the rating for this key question as although some improvements had been made, the provider had not made sufficient improvements in all areas and we did not see evidence of sustained improvement over time. We will check this again during our next comprehensive inspection.

Is the service responsive?

Requires Improvement

The responsiveness of the service had improved.

We saw that improvements had been made in how the provider received and acted upon complaints.

Where shortfalls had been highlighted, action had been taken to address the concerns raised.

We were unable to change the rating for this key question as to do so requires evidence of sustained improvement over time. We will check this again during our next comprehensive inspection.

Is the service well-led?

Requires Improvement

The service was not always well-led.

We saw that improvements had been made in relation to notifiable incidents which the provider has a legal responsibility to do so.

We were unable to change the rating for this key question as to do so requires evidence of sustained improvement over time. We

will check this again during our next comprehensive inspection.

AQUAFLO CARE LIMITED

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to check that improvements to meet legal requirements planned by the provider after our inspection on 31 January, 1 and 2 February 2017 had been made.

The inspection took place on 8 and 13 June 2017 and was announced. The provider was given 24 hours' notice because we needed to ensure somebody would be available to assist us with the inspection.

The inspection team consisted of two inspectors, with one present on both days of the inspection and one on the first day. Before the inspection we reviewed the information the Care Quality Commission (CQC) held about the service. This included notifications of significant incidents reported to the CQC and the previous inspection report. We spoke with all three local authority commissioning and safeguarding teams and shared information following the previous inspection.

We tried to contact six people using the service whose files we reviewed but only managed to speak with two relatives. We also spoke with 13 staff members which included the director, two operations managers, the registered manager, a branch manager, two care coordinators, two human resources officers, an assessor and three care workers. We looked at 12 people's care records, which included three people's medicines administration records (MAR), staff training records and records related to the management of complaints and notifiable incidents.

Before, during and after the inspection we spoke with five health and social care professionals who worked with people using the service for their views and feedback.

Requires Improvement

Is the service safe?

Our findings

At our last comprehensive inspection on January 31, 1 and 2 February 2017 we found that people's safety was at risk. Where risks were identified risk management plans did not have guidance for staff to minimise and mitigate the risk to people using the service. Where people were supported with their medicines, the relevant assessments were not completed and medicines records were not completed to ensure people received their medicines safely. We issued a warning notice to the provider asking them to make improvements by 11 May 2017.

During this inspection we found that some improvements had been made, but they were not consistent throughout all the files we reviewed.

Since the previous inspection, the provider had updated people's care records onto an online system. A branch manager told us that the system went into a lot more depth regarding risk assessments and medicines. They added, "It's online and we do print them out and put them in people's care files." Although improvements had been made in the level of information recorded in people's files, not all care plans had been updated to reflect the current level of care being provided. The director acknowledged that when people's needs changed their records needed to be updated to highlight the change in care and identify any further risks.

We looked through seven of the same care files where we had found concerns at the previous inspection. We saw that they had all been updated and improvements were found in the level of detail of information recorded. For one person who was at risk of falls, we saw guidance for staff about minimising the risk and that they needed to be supervised during all mobility transfers. There was information about mobility equipment and where it should be placed, along with ensuring any spills were cleaned up and pathways were left clear before finishing the call.

For another person who was at risk of pressure sores, we saw that information about being repositioned during visits was recorded in their assessment, which had not been recorded at the previous inspection. It recorded when it needed to be done and we saw notes in daily communication records that care workers were aware of this. However, for another person that needed the same level of care, this had not been recorded in their risk assessment or care plan. An assessor told us that it would be updated right away.

Where we found risk assessments to be lacking detail, we found that the provider had updated them by the time we had returned for the second day. For example, one person was at risk of behaving in a way that challenged the service. Their care plan stated, 'My behaviour can be quite challenging at times', but there was no further information about the kind of behaviour displayed or guidance for staff on how to manage it. On the second day of the inspection an assessor showed us that they had spoken with care workers to get further information to update their records. However, we saw records for another person where the local authority assessment had highlighted that they were at risk of having seizures, but this had not been included in their risk assessment.

For two people who needed support with transfers using a hoist, we saw that this had been recorded in their files with guidance for care workers to ensure care tasks were carried out safely. Care workers were reminded to apply the brakes to the bed and had specific positions for equipment, however after further inspection we saw correspondence that said a hoist was not currently being used due to the suitability of the premises. Neither care plan had been updated to show the change in needs or how care was being currently being carried out. The provider acknowledged that they needed to be updated.

Relatives we spoke with said that they had no concerns about the safety of the care that was given. One relative said, "The care workers are fully aware of their needs and we don't have any safety concerns." Another relative said, "I work very closely with the carers and have had them for a long time. I'm happy with the care they receive and have no concerns at present."

Where people were supported with their medicines, we saw that improvements had been made in how they had been recorded in people's files. At the previous inspection there was very limited information about people's medicines. We saw information had been included to show who was responsible for collecting and ordering people's medicines, along with how they were supported. Lists of people's medicines were recorded along with the dose, what the medicines were for and any specific instructions about how they had to be taken. For example, one person's record highlighted if a medicine needed to be taken before or after food or chewed instead of swallowed.

Another person had been supported with using a topical cream. An assessor showed us a previous care plan where it had been recorded and a body map was in place for care workers to see where it had to be applied. The cream had been stopped for health reasons and we saw that the care plan had been updated and care workers were made aware as it had stopped being recorded in the person's daily communication records.

However this was not always consistent in all the files we reviewed. We saw another person was supported with a topical cream but this had not been recorded in their care plan. This had been updated by the second day of the inspection. Another person's medicines records had also not been fully updated to record a recent change in their medicines. The care plan in the person's home had not been updated and a branch manager told us they were in the process of updating the online record. We spoke with three care workers who supported this person and they had been aware of the change in their medicines and had liaised with the office and the GP and knew what medicines the person needed to be supported with.

Where there was confusion over whether care workers prompted or assisted this person with their medicines, a branch manager showed us confirmation from care workers about how they were supported. The provider found that a number of care workers, where English was not their first language, had recorded in people's communication records that they gave people their medicines, when in fact they had been prompted. We saw that the provider was already aware of this and had care worker meetings arranged to discuss this issue and to remind care workers about the appropriate wording when filling out daily communication records.

At the last inspection, there were no medicines administration records (MAR) available for all the files we viewed so we could not be assured that people had received their correct medicines, at the correct time. We were told that they were in the process of implementing a monthly return of all records to be checked. We saw that this was still in the process of being implemented at the time of the inspection. The registered manager showed us newly designed communication books that included MAR sheets, which only had enough records for one month, so they would need to be returned to the office to be checked once they had been completed.

We were only able to view three people's MAR sheets and found inconsistencies in all three of them as they had not been filled out correctly. For one person's records, we saw that up to eight different medicines had been recorded in a single record chart, rather than having an individual record for each medicine administered. It was unclear at what times individual medicines needed to be taken and what the quantity and frequency was.

For another person, all of the recordings had been completed on the reverse side of the MAR chart, which is to be used to explain and record why medicines were not given. Care workers did not have an understanding on how to fill out the MAR charts correctly. Within the same records, we saw that this person received PRN medicines. This is an abbreviation of 'Pro Re Nata' and is commonly used on medicine administration charts to indicate that a medicine should only be given 'as needed'. We found a number of examples when PRN medicine was given, but the name of the medicine, the dose and why it was taken was not recorded. For example, from the 12 May to 21 May 2017, painkillers were recorded on the MAR sheet but there was no further information available. This level of recording was not in line with the provider's own policies and procedures relating to PRN medicines. We also saw a number of gaps when medicines had not been recorded but no further information to explain the reason why they had not been given. We spoke to the registered manager about these issues and they acknowledged that sufficient checks had not been in place to identify these recording errors. They added that they were already aware of the issues as they had started to return people's communication books more regularly and saw that people's MAR charts were not being filled out correctly. Meetings for care workers had been arranged for the 9, 12 and 13 June to discuss this issues and we saw an agenda which showed that this topic was to be discussed.

Although there had been some improvements since the last inspection, the above information demonstrates a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were unable to change the rating for this key question as although some improvements had been made, the provider had not made sufficient improvements in all areas and we need to see evidence of sustained improvement over time. We will check this again during our next comprehensive inspection.

Requires Improvement

Is the service responsive?

Our findings

At our last comprehensive inspection on January 31, 1 and 2 February 2017 we found that there was a continued breach of requirements relating to receiving and acting on complaints. Complaints had not been acted upon and proportionate action was not taken in response to identified failures. We issued a warning notice to the provider asking them to make improvements by 21 April 2017.

During this inspection we found that improvements had been made and the provider was now meeting this regulation.

The registered manager had created a folder which had highlighted the shortfalls from the previous inspection that had been included in the warning notice. We saw that three complaints from the previous inspection had now been followed up and investigated, and it had been acknowledged where staff had failed to pass information onto the relevant people. The registered manager told us that they had made sure that each complaint was thoroughly investigated and we saw a number of actions that had come out from their findings.

We saw that all complaints were now forwarded to a dedicated email address, along with the registered manager so they would be aware of any concerns or complaints that had been raised. All concerns should also be raised with the responsible local authority and we saw the provider had done this. For example, one care worker had raised some concerns about a person's wellbeing, when the provider was having difficulties engaging with the person. We saw correspondence that the provider had raised the concerns with the local authority and kept the care worker updated.

We saw that once investigations had been completed, the provider had taken appropriate action. We saw that people and relatives had received a response to their complaints and acknowledged when they had been let down. The provider had been able to meet with one relative to discuss their concerns and then sent a letter highlighting the outcomes of the investigation. For another person where there were concerns from the previous inspection, we saw that a spot check had been carried out the following day to meet the person and follow up the complaint. We saw examples where disciplinary action had taken place and members of staff had received refresher training. Staff also attended supervision sessions to discuss the issues raised and were reminded about the importance of following policies and procedures. We saw one positive response from the local authority after actions taken by the provider had resulted in a change of care worker for a person. We saw that the person was very happy with this and the health and social care professional wanted to pass this feedback onto the member of staff involved.

We reviewed one complaint that had been received after the last inspection and saw that it had been recorded and was in the process of being investigated. A detailed investigation had already started and the registered manager had obtained a number of statements from staff involved in the incident. The registered manager told us that they would let us know their findings, along with informing the local authority once it had been completed.

A relative told us that they responded very quickly and were very prompt in dealing with an issue they had raised. They added, "The managers and care coordinators are very approachable and I was happy with how they dealt with the situation."

We were unable to change the rating for this key question as to do so requires evidence of sustained improvement over time. We will check this again during our next comprehensive inspection.

Requires Improvement

Is the service well-led?

Our findings

At our last comprehensive inspection on January 31, 1 and 2 February 2017 we found that there was a continued breach of requirements relating to notifiable incidents. We found evidence of three incidents that had not been notified to us, which should have been. We issued a warning notice to the provider asking them to make improvements by 21 April 2017.

During this inspection we found that improvements had been made and the provider was now meeting this regulation.

We saw that the three incidents that had not been notified to us from the previous inspection had been followed up and investigated appropriately. The registered manager told us that notifications had been discussed since the previous inspection and that they would make contact with the Care Quality Commission (CQC) if they were unsure. The provider had done this and had made contact with us asking for advice regarding a statutory notification. Once advice had been given, the relevant notification was submitted.

We also reviewed another notification that we had received since the last inspection. We saw that it had been logged and an investigation had been carried out, with outcomes shared with the responsible local authority. Actions had been carried out and we saw staff had received further training and an assessment had been carried out by one of the assessors. We spoke with the relative of the person the notification was related to and they confirmed that they were happy with the care workers who were supporting her family member and had no concerns. They added, "I do work very closely with them and they do get back to me."

We were unable to change the rating for this key question as to do so requires evidence of sustained improvement over time. We will check this again during our next comprehensive inspection.

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 The provider did not ensure that care and treatment was provided in a safe way as systems for the proper and safe management of medicines were not operated effectively. Regulation 12(1),(2)(g)