Aroma Care People Ltd

Aroma Care Northampton

Inspection report

Brook House
6 Edmonds Close, Denington Industrial Estate
Wellingborough
NN8 2QY

Tel: 01604926066

Date of inspection visit:
13 December 2021
14 December 2021

Date of publication:
26 January 2022

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Aroma Care is a domiciliary care service. It is registered to provide personal care to people living in their own homes in the community. At the time of the inspection there were 33 people receiving personal care and support.

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
The provider continued to fail to have sufficient systems and oversight to assess, monitor and mitigate the risks relating to the health, safety and welfare of people. Care plans and risk assessments lacked essential information so that staff could provide appropriate care and support safely.

Systems in place to ensure people received their medicines as prescribed needed to be strengthened to ensure they were more robust and effective.

There was a high level of dissatisfaction in relation to people's care calls that included people experiencing missed and late calls, a lack of consistency of staff and staff not staying for the allocated time of the care call.

Systems and processes to engage with people were not always effective at identifying the level of dissatisfaction we received from people and relatives about the times and length of their care calls.

People expressed frustration about the poor communication systems in place, the lack of response to complaints and the attitudes of some staff. Some people did not feel they received person centred care.

The systems in place to assess, monitor and improve people's quality and safety of care needed to be strengthened to ensure people received the care they needed, at the time they required so their needs could be fully met.

There were systems and processes in place to safeguard people from potential harm. Staff completed training about safeguarding people from harm; we were not able to assess staff understanding and knowledge around safeguarding as we were only able to speak with one staff member.

The provider had improved their recruitment practices to ensure people employed were suitable to work at the service and support people.

Effective systems were in place to control and prevent the spread of infection. People told us that staff

always wore PPE when carrying out personal care.

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

Rating at last inspection:
The last rating for this service was Requires Improvement (30 April 2021)

At this inspection enough improvement had not been made/sustained and the provider was still in breach of regulations

Why we inspected:
The inspection was prompted in part due to concerns received about staffing. A decision was made for us to inspect and examine those risks.

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 two continued breaches in relation to safe care and treatment and good governance and a further breach of regulation in relation to staffing.

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.

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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Aroma Care Northampton

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team
This inspection was conducted by two inspectors and two experts by experience. 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
Aroma Care is a domiciliary care service, registered to provide personal care to people living in their own homes in the community.

The service did not have a manager registered with the Care Quality Commission. This means that the provider is 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 short notice of our inspection. This was because we needed to be sure the registered manager would be available to support the inspection.

Inspection activity started on 13 December 2021 and ended on 14 December 2021. We visited the office location on 13 December 2021.

What we did before the inspection
In planning our inspection, we reviewed information we had received about the service. This included any notifications (events which happened in the service that the provider is required to tell us about) and feedback from the local authority.

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.

During the inspection
As part of the inspection we spoke with nine people using the service and 19 relatives. We had discussions with the manager, care coordinator and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We attempted to contact a further eight care and support staff by telephone and email. We received a response from two staff. One did not speak English, so we were not able to have a discussion about Aroma Care with them, but we did speak with the other staff member who responded to our call.

We reviewed a range of records that included four staff files in relation to recruitment and staff supervision and a variety of records relating to the management of the service, including staff rotas, accident and incident analysis, the complaints log and quality assurance records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at three care plans and associated risk assessments for three people, staff training matrix and governance information.

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 assess all risks to service users and to ensure the safe and proper management of medicines. 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 improvements had been made at this inspection and the provider was still in breach of regulation 12

Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong

● There were risk assessments in place for most areas of identified risk with some control measures to reduce risk. However, some risk assessments lacked detail. For example, in two people's medication risk assessments it was recorded 'carers to apply creams.' There was no information about the creams to be applied or where they should be applied. This meant there was a risk that people may not have the appropriate creams applied as prescribed.

● Four relatives told us their family members did not receive their medicines at the times prescribed because of late calls. One said, "[Family members] medication is not given at the right time due to missed calls and late calls. "Another relative said, "Sometimes they don't arrive until 11am. That's too late for [family members] medicines to be given."

● We identified an unsafe practice during one of our calls where the relative told us they filled a Dossett box with their family members medicines weekly and staff supported the person to take their medicines. This is not in line with best practice and Dossett boxes should be filled by a pharmacist if staff are supporting people with their medication.

● One relative told us their family member had a visual impairment and was concerned the staff did not put things back in their expected place, so they were familiar to the person. This had resulted in the person spraying themselves with air freshener instead of deodorant. There was no information or risk assessment in place for staff to follow to ensure the persons surroundings remained familiar to them.

● In one person's health risk assessment it recorded the person suffered from pain in their legs. However, there was no pain relief information or guidance for staff to follow if the person complained of pain. This meant the person may not receive the appropriate pain relief when required.

● In another person's health risk assessment, it recorded they were at 'medium risk' of needing support with depression. The risk reduction measures in place were for the 'care worker to read and follow care plan and risk assessments.'. However, there was no guidance in place for this person regarding depression and what steps staff needed to take. This meant the person was at risk of their mental health needs not being appropriately addressed.

● Care plans lacked essential information so that staff could provide care and support safely. For example, in one person's care it recorded that the person was 'bed bound' and they required support with personal

care. The details of tasks to be delivered were recorded as 'all personal care to be carried out in bed, assistance to get dressed and hoisted onto the commode and given choice to be hoisted into chair.' These are vague statements and do not direct staff how to deliver safe and appropriate care.
● One person's care plan described the person as being 'at risk of falls' but there was no falls risk assessment in place. We queried this with the manager who confirmed there was no specific falls risk assessment and it would be covered in their health risk assessment. However, there was no information in the health risk assessment either.

The provider had failed to robustly assess the risks relating to the health safety and welfare of people and to ensure the safe and proper management of medicines. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There was a lot of dissatisfaction expressed about the punctuality of people's care calls. One relative told us, "They turn up to help [family member] at 11am for breakfast then no one will arrive to cover lunch call or in the evening." Another told us, "The late calls and only having time to make [family member] a sandwich impacts on [family members] health."
● Nine people and/or relatives expressed frustration about having missed calls. One person told us, "It is very common for the office to say that no one will be coming." A relative said, "I have read 'Visit completed' on the App but it hadn't taken place." Another commented. "Sometimes they don't turn up. When its past 10.00pm I need to sort my [family member.] It's been a struggle." Another comment was, "If [family member] has a missed call at night they go to bed still dressed."
● Some people were happy they had regular staff to provide their care but some voiced concerns about a lack of continuity of staff. One person said, "There sometimes is not the consistency of regular carers and I worry as I have [mental health condition]." A relative told us, "My [family members] mental health has declined due to lack of care and the lack of continuity. With different faces coming and going [family member] had no recognition of any carers."
● People also expressed frustration that staff did not always stay for the time allocated to the care call and did not carry out all the required tasks. Comments included, "Some of the carers attitude is not good, they rush the care and leave within 10 minutes when the call is for 30 minutes," "Some wash up, make a quick sandwich and are gone in three to four minutes."
● We requested the daily notes for two people to check what care had been carried out and how long staff had stayed at each call. We did not receive the requested information.

The provider failed to ensure that people received timely and consistent care. This was a breach of Regulation 18 (Staffing) Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A number of documents were missing from staff recruitment files. We spoke with the Nominated Individual (NI) about this and ascertained most of the missing items were historical. The NI stated they had employed a company to ensure all recruitment documents were now in place prior to new staff commencing at the service and to ensure the process was more robust. The NI told us they would address the historical shortfalls to ensure all necessary checks were in place.

Systems and processes to safeguard people from the risk of abuse
● Most people told us they felt safe when receiving personal care. One person told us, "I feel safe when they are with me. I ask them to do things for me and they complete the tasks well." A relative commented, "They are a God send to us and we are very lucky to have them."

● One person told us how the manager was helping to do their care calls and said, "I feel quite safe now though and the manager is approachable and friendly. I can talk to them."
● One relative expressed concern about the way some staff supported their family member with moving and handling which made their family member feel unsafe. Another relative told us that their family member often had late calls in the evening which left them feeling anxious and frightened when staff did not arrive when expected. Staff did not call to let them know if their care call was going to be late.
● The training matrix showed that staff had received training in how to keep people safe from potential harm. However as we had a poor response from staff and were only able to speak with one care and support worker, we were not able to assess whether staff had a good understanding of safeguarding people and were able to recognise signs that might indicate a person was being abused.
● The registered manager was aware of their responsibility to liaise with the local authority if safeguarding concerns were raised.

Preventing and controlling infection
● COVID-19 checks were not completed for the inspectors on their arrival to the office of Aroma Care Northampton in line with current best practice.
● Everyone we spoke with said all staff wore personal protective equipment (PPE), washed their hands and cleaned surfaces to reduce the risk of cross infection. A relative said, "They wear an apron, mask and gloves and they change them."
● The staff training matrix showed that most staff had completed training in how to minimise the risk of infection for people and had information in the providers policies which they could refer too.
● Staff practices were checked by the management team to ensure infection control procedures were followed; this was done by completing an unannounced spot check of the staff members practice.

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 Requires Improvement. At this inspection this key question has remained the same. 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 systems and processes were not effective or robust enough to monitor the quality and safety 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 improvements had been made at this inspection and the provider was still in breach of regulation 12

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;

- Systems and processes seeking people's views were not always effective. We saw that monthly telephone checks were completed to see of people were happy with the care they received. These had failed to identify the high level of dissatisfaction we received from people and relatives about the times and length of their care calls and poor communication.
- Some people and their relatives told us that staff did not always provide person centred care. One person said, "There is no conversation from some of them [meaning staff] and the care provided is undignified." A relative told us, "We went to visit [family member] as a family and when the carer arrived, she said, 'oh you can make [person] a cup of tea' and then left without doing anything." Another relative commented, "Last [day of the week] when one of the girls [staff] came, they only washed [family member's] face, that is all and [family member] was most upset as the carers attitude was not good and quite awful."
- There was a poor response from staff who did not respond to our requests via email and telephone calls to talk with us about working at the service. This did not demonstrate an open and transparent culture.
- People and relatives expressed dissatisfaction regarding poor communication with the office staff and management team. Comments included, "There is no communication from the office." "We will ring the office and get no answer." "[Family member] is never informed if they [staff] are late. [Family member] will ring me in tears if they [meaning staff] haven't arrived." "I get zilch. Not even a rota."
- Some people were dissatisfied about how the management responded to complaints. A relative said, "When we have raised a complaint, the office has no record of any call we made or conversations. They just say to us we have looked into this but there is nothing logged." Another relative commented, "When I phone the office there are no records of any complaints or calls that I have made." One person said, "Whenever I call the office to raise issues, they are most unhelpful and do not seem to care at all." The complaints log showed two complaints had been recorded since Feb 2021 which was not consistent with the level of dissatisfaction we received from people and relatives about the service.

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

● There was no registered manager in post, though a new manager had been recruited for the Northampton branch. We asked them what stage they were at registering with the Care Quality Commission. They were unsure about the process.

● We received mixed views from people and relatives about the management of the service. Most people praised the manager and told us they were helping out with their care calls. One said, "[Name of manager] is working extra hard to fill in the shortages of staff, so can't do the managerial stuff and doesn't want to let people down. It's amazing what [name of manager] is doing." However, there was dissatisfaction with the organisation of the service, care calls and poor communication.

● There was a lack of detailed and personalised information within people's care plans and risk assessments so that staff could provide care and support safely. These shortfalls had not been picked up by the provider's quality monitoring checks.

The provider had failed to ensure systems and processes were effective and robust enough to monitor the quality and safety of the service. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The provider had invested in the service. Information about people's care, staff records, and management information had been transferred to a new electronic care management system. This system would enable the registered manager to monitor more effectively and identify trends so action could be taken promptly. However, this had not become embedded into staff practice at the time of our visit.

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; Working in partnership with others

● The provider understood their responsibilities in relation to duty of candour. Duty of candour requires providers to be open about any incidents in which people were harmed or at risk of harm.

●The management and staff team worked in partnership with other professionals and agencies such as the GP, district nurses, Occupational therapists and the local authority.

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 HSCA RA Regulations 2014 Staffing The systems in place did not ensure that people received the care they needed, at the times they required to meet people's assessed care and support needs.

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 provider had failed to robustly assess the risks relating to the health safety and welfare of people and to ensure the safe and proper management of medicines.

The enforcement action we took:

We issued a warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure systems and processes were effective and robust enough to monitor the quality and safety of the service.

The enforcement action we took:

We issued a warning notice