Aurora Home Care Ltd

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Inspection report

Unit 37
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Tel: 01915800920

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25 August 2022
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08 September 2022
14 September 2022

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Aurora Home Care Ltd is a domiciliary care agency providing personal care to a range of people with health and social care needs in their own homes. At the time of the inspection, 63 people received 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
Quality assurance checks were poor and although the provider had numerous good systems in place, they were not fully utilised.

Risks to people's health, safety and welfare had not been consistently reviewed to make sure measures were in place to reduce the risks. Many care plans had not been regularly updated and some were still on the providers previously registered service paperwork.

Staff training was not robust, and staff told us they were not supported.

Medicines were not always managed well. For example. when people required medicines on an 'as required' basis, the guidance for staff had not been consistently completed. Staff medicine competencies had not always been carried out effectively.

Infection control procedures were not always safe. Staff had not always followed guidance. We have made a recommendation about this.

The provider had enough staff to support people although some staff were absent due to sickness, and others were new to the organisation. The rota system for planning care calls was not well organised which made it difficult for staff to arrive on time and stay for the amount of time required. We have made a recommendation about this.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People and their relatives confirmed care staff were kind and caring. People received meals and drinks in line with their care plan. Staff worked well with other health and social care professionals.

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 good (published 3 October 2020).

Why we inspected
We received concerns in relation to the care people received and the management of the service. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection. Please see the safe, effective 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 full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Aurora Home Care Ltd on our website at www.cqc.org.uk

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, staffing and governance 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 from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Aurora Home Care 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 Health and Social Care Act 2008.

Inspection team
The inspection was completed by one inspector and an Expert 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
This service is a domiciliary care agency. It provides personal care to people living in their own homes.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 25 August 2022 and ended on 14 September 2022. We visited the location's office on 25 and 30 August 2022.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

We contacted local authority commissioners and safeguarding teams; and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used this information to plan our inspection.

During the inspection
We spoke with six people and ten relatives. We met with the registered manager, a director, the nominated individual, the business development manager and the regional operations manager. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We contacted every member of care staff via email (50) to gather feedback. We also contacted 15 staff by telephone.

We reviewed ten people's care and medicine records. We looked at four staff records in relation to recruitment, training and supervision. We also looked at a variety of records relating to the management of the service and quality monitoring systems.

We contacted two district nurse teams, nine care managers and two occupational therapists for their feedback about the service.

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. 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.

Using medicines safely

- Medicines were not always managed safely. Two different systems were in place for staff to record administration of people's medicines; paper and electronically. One staff member said, "I have not been shown how to use it [electronic system], it's just what I have picked up off others. Not sure why we are recording things twice anyway!"
- 'As required' medicines protocols were not always in place. Topical medicines such as creams, did not always have full details of where the medicine should be applied, and records were not always completed to show the application had been applied as prescribed.
- Staff competency checks were not robust and often occurred in the providers office and not in people's homes. One staff member said, "It's an accident waiting to happen. How can you tell if staff are any good if you don't even come out to watch them?"
- Care staff were often responsible for putting new monthly medicine administration records in place with no clear oversight from the registered manager.
- Medicine audits had been carried out, but these were not robust enough to identify the concerns we found.

The provider did not have robust medicines management procedures in place to keep people safe. This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risks to people and staff had not always been identified, assessed or reviewed. This included the risks in connection with COVID-19. Some people's risk assessments were less detailed or had not been reviewed for over two years.
- The registered manager acknowledged further work was needed to update these.

No harm had occurred to people, however, the provider's procedures for assessing, reviewing and managing the risks to people's health and safety were not robust. This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- The provider had enough staff. However, due to sickness and staff leaving this had impacted on the business. The provider had a continuous recruitment drive in place to address this.
- Care calls were not well planned, and some calls overlapped. People did not always receive their calls at

the time agreed nor did staff always stay for the allocated time. One person said, "I feel safe when the carers call but they don't always stay for the time they are supposed to which is sad as I like the company." Another person said, "Timings of calls can be an issue as I think they are short staffed." The management team were in the process of further reviewing rotas.
● People did not always know which member of care staff would be attending their care call. One person said, "We don't have a rota."

We recommend the provider fully review their rostering system to ensure care calls are managed well in line with people's agreed needs.

● Safe recruitment checks were in place. This included Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. One staff member was placed in single staff care calls without a full enhanced DBS check in place. A director told us this should not have occurred as it was against their policy.

Preventing and controlling infection
● The provider did not have robust infection control procedures in place. Staff could not tell us how to put on or take off PPE in line with current guidance. The provider took immediate action to address this.
● One person told us staff did not wear masks any longer at their request. The director was going to address the matter immediately as they told us they were unaware of this issue.
● The provider's infection prevention and control policy was up to date, although not always followed by staff. Two care staff told us not all staff wore aprons and one person confirmed this.

We recommend the provider review their procedures, including training, in line with government guidelines and best practice.

Learning lessons when things go wrong
● The registered manager told us lessons were learnt when things went wrong, but this was difficult to evidence because of poor record keeping.
● Systems were in place for staff to report accidents or incident. The provider had processes to routinely analyse accidents and incidents to improve the safety of the service, but the outcomes were not always fully recorded.

Systems and processes to safeguard people from the risk of abuse
● People, and their relatives confirmed, they felt safe. One relative said, "My [relative] is safe with the carers as they are kind and treat them well and are careful when they take them into the bathroom for personal care."
● People were protected against the risk of harm and abuse as staff members knew how to identify, respond to and escalate suspected abuse. Not all staff had completed safeguarding adults training.
● The registered manager liaised with the local authority and undertook appropriate investigations when allegations occurred.
● The provider had up to date safeguarding and whistle blowing policies and procedures in place.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff induction and training was not robust. Training deemed mandatory by the provider had not been completed for all staff. Staff said they had not been provided with face to face moving and handling training. One relative said, "There have been some issues with manual handling and new staff not transferring [person] appropriately." Another relative said, "The staff are very kind and caring, but their training needs to be reviewed."
- Not all staff knew what the care certificate was or if they had completed it. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
- Staff did not feel supported. Staff supervision had not been completed as expected by the provider. Staff meetings had not occurred regularly. One staff member said, "I don't feel supported at all." Another said, "Most staff are either leaving, have left or are thinking about leaving."

The provider had failed to ensure staff were always suitably trained and fully supported. This was a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs had been assessed, but not every person had been regularly reassessed to ensure the provider continued to meet their needs. Some people's care records had not been reviewed for over two years. The provider was in the process of addressing this.
- Most people and their relatives said staff followed their instructions on what care to provide, without care records being updated.
- Where people were placed by the local authority, there was a record of agreed assessment needs and care delivery hours.

Supporting people to eat and drink enough to maintain a balanced diet

- People were supported to maintain a balanced diet. Care plans detailed people's food and drink preferences and any specialist dietary requirements. People and relatives told us staff offered choices with the meals they prepared.
- People and their relatives were satisfied with the quality of support they received with eating and drinking.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Staff worked well with other health and social care professionals and ensured timely referrals when needed. One healthcare professional said, "We have had no areas for concern with this [person]. No issues with the skin damage; the staff have carried out instructions well."

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

● Staff followed the requirements of the MCA. People told us consent was requested before care was agreed or undertaken.
● Staff had received training in the MCA. Best interest decisions were in place when required.
● No person was under the court of protection at the time of the inspection.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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.

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

- We were not assured the registered manager was clear about their role nor did they have a good oversight of the running of the service.
- Quality assurance monitoring was not effective. Audits and checks completed had not identified the issues we had during the inspection.
- Record management needed to be improved, including care records and medicines records.

We found no evidence people had been harmed, however, robust governance procedures were not in place to effectively manage the service. This was a breach of Regulation 17 (governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider understood their responsibilities with regards to the Health and Social Care Act 2008 and what they needed to notify CQC about without delay.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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 registered manager had not always promoted a positive, open and inclusive culture. We received mixed views. One person said, "I am just sick of staff saying, 'it's a medical emergency' when they are late… just tell the truth, because I know it's because they are short staffed." One relative said, "Sometimes the office doesn't follow through on requests that I make." A staff member said, "The management don't seem to respect each other or the staff that work for them." Another relative said, "The carers and office staff are polite and respectful, and I consider them to be extended members of the family."
- Staff felt unable to raise concerns with the registered manager because of fear of not being listened to or what might happen as a result.
- The registered manager understood their responsibility under duty of candour. No incidents had occurred which required the registered manager to taken action in relation to duty of candour.

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

- Staff did not feel included in how the service operated. Many had not had the opportunity to attend team meetings or receive minutes.

● People and their relatives gave mixed views on being engaged and involved with the service they received. Some people were happy with the level of contact they received and felt fully engaged, whereas other people said the opposite and had little contact with the office staff.

Continuous learning and improving care

● The provider had implemented several new systems to improve the service. However, these were not always utilised fully.

● After feedback, the director took immediate action and made changes to address some of the issues we had brought to their attention. These changes required time to embed and ultimately drive improvement to the outcome of people's care.

Working in partnership with others

● The management team worked in partnership with others. All professionals communicated with had no concerns to raise and said staff had worked with them for the benefit of people they supported.

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 Medicines were not robustly managed. Risks to people were not always reassessed and monitored fully to ensure people remained safe. Regulation 12(1)(2)(a)(b)(c)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Care records were not kept up to date and governance procedures were not robust. Regulation 17(1)(2)(a)(b)(c)(f)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not fully supported and had not always received full and suitable training. The provider did not have effective competency checks in place. Regulation 18(1)(2)(a)