A&A Services West Midlands

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
A & A Services West Midlands provides personal care to people, inducing older people living in their own homes. There were 11 people using the service at the time of our inspection.

People's experience of using this service and what we found
People were not always protected from potential abuse as incidents of potential abuse had not always been recognised and procedures were not always followed. When incidents had been recorded these were not always appropriately investigated or reported. There were no systems in place to monitor the care people received, this included monitoring care records, medicines and call times. There was a lack of oversight in the service that left people at risk of potential harm and information was therefore not sought to make improvements where needed. Lessons were not consistently being learnt.

Complaints were not always responded to in line with the providers policy. Staff were not always safely recruited to ensure their suitability to work with people. There were no systems in place to ensure staff had the skills and training to support people.

When people's care had been assessed plans were in place for staff to follow. Further improvements were needed to ensure these covered health conditions.

Support with meals was offered when needed. Staff were kind and caring towards people and they felt safe, they were left comfortable after visits.

Referrals or appointments were made on behalf of people when they needed support with their health.

There were infection control procedures in place, and they were followed. 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 support this practice.

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

Rating at last inspection
This service was registered with us on 14 September 2022, and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about the care people received and the records that were in place, how staff were recruited and the culture of the service. A decision was made for us to inspect and examine those risks.

You can see what action we have asked the provider to take at the end of this full report.

We found no evidence during this inspection that people were harmed from the concerns we identified. However there was an increased risk of harm as people were not always protected from potential abuse. Please see the safe, effective, caring, responsive and well-led sections of this full report.

Enforcement
We have identified breaches in relation to how complaints were dealt with, how staff were recruited and how people were protected from potential abuse. We also found concerns with how the service was governed and the systems in place to monitor the care people received.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

A & A Services West Midlands

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 carried out by 2 inspectors and an Expert by Experience, who made telephone calls to people 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.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had recently been appointed and had submitted an application to register.

Notice of inspection
We gave the service 18 hours' notice of the inspection. This was because we needed to be sure that the

provider or registered manager would be in the office to support the inspection.

Inspection activity started on 27 September 2023 and finished on 29 September 2023. We visited the location's office on 27 September 2023.

What we did before the inspection
We reviewed information we had received about the service since our last inspection, including notifications the provider had sent to us, information from the local authority and the public. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with 3 people and 4 relatives. We also spoke with the nominated individual, the manager and 5 care staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We looked at the care records for 7 people. We checked the care people received matched the information in their records. We looked at records relating to the management of the service, including audits carried out within the service and recruitment records.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection of this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- The systems in place to ensure people were protected from abuse were not always followed as incidents were not always recognised or reported.
- When incidents had occurred, these were not always investigated and reported to the safeguarding team. For example, we saw documented on body maps people had unexplained bruising and people had missed calls, no further action was taken. This meant people had experienced potential abuse.
- Staff told us they had received training and were able to explain safeguarding to us. They told us the action they took to keep people safe, including documenting and reporting concerns to the office. However, there were no systems in place to ensure these concerns were then followed through, placing people at an increased risk of potential abuse.

People were not always protected from potential abuse as incidents were not always investigated or reported so that action could be taken. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment

- Staff were not always safely recruited. There were gaps in staffs' recruitment records. For example, staff were not asked to provide a history of their employment and employment references from previous employers had not always been obtained.
- There were no systems in place to monitor staff files or the recruitment process. One staff member did not have evidence of a Disclosure and Barring Service (DBS) check in their files. The provider was not aware of this. The staff member later provided a copy of this. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

The lack of pre-employment checks placed people at risk of not receiving support from appropriate staff. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- There were enough staff available to support people and their care was planned. However, on occasion people told us they had not received their call. There were no systems in place to monitor people's calls, including if they were on time, the length of them and if they had taken place.
- People and relatives were mostly happy with the calls and told us staff would contact them if they were going to be late. One person said, "Carers are roughly on time within 15 minutes. Today they were a bit late as they were training a new worker. They phone me if they are going to be late." A relative said, "I get a

message to say they will be delayed by up to half an hour. It's happened once in the last couple of weeks."

Assessing risk, safety monitoring and management

● There were not always individual care plans in place for people when needed. For example, when people had health conditions. Although staff were able to tell us how they would support people with these conditions, the lack of care plans placed people at risk of not receiving the support they needed.

● Other people had care plans in place that identified their risks and how these should be managed. This included when people were at risk of falls.

● Most of the care plans and risk assessments we viewed were not dated, it was therefore unclear if these were being reviewed or completed when needed.

● People and their relatives were happy with the care they received and felt safely supported by staff. One relative told us, "It's absolutely safe. The care is first class. Everything done for my relative has thought for their needs. My relative's needs are paramount. They (staff) dress my relative every day and are gentle with they're washing them."

Medicines management

● Medicines administration records were not consistently completed. For example, these were handwritten, and we saw dosages were not always recorded. We also saw signatures were missed by staff. On occasion it was documented in people's daily records they had received these medicines.

● People told us they had received their medicines and were happy with how these were administered. One person said, "I have health problems. The carers give me my medicines and I take them from a cup".

● There was no oversight of medicines by the provider to ensure the safe administration of these. Although staff had received training to administer medicines, they told us and records confirmed their competency was not checked to ensure they were safe to do so. We also found MAR charts for previous months were not available for review.

Learning lessons when things go wrong

● There were no incidents and accident forms in place despite daily records identifying concerns. This meant no action had been taken to resolve these incidents, review people's care and learn from these.

● There was some evidence in other areas that lessons had been learnt. Following a recent safeguarding the manager had introduced a log, identifying any learning from this, including how things could be done differently and how this could be shared with staff.

Preventing and controlling infection

● People were supported in line with infection control policies.

● Staff told us they had received training and had access to gloves and aprons which they used when they were offering support to people in their own homes.

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.

This is the first inspection of this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People did not consistently have their needs assessed. We found for 1 person there was no assessment in place. For other people their needs had changed, and records were not reflective of this, for example when people were now supported with medicines.
- It was unclear if assessments and care plans were reviewed when people's needs changed as there were no dates on records. This meant we could not be sure people were receiving the care they needed.
- When people did have assessments in place their gender, culture and religion were considered to ensure their needs could be met.

Staff support: induction, training, skills and experience

- People and relatives felt staff had the skills to support them. One relative said, "I think, by and large, they have the training to do the job. I am not sure how much training they get on Alzheimer's at the beginning. They (carers) deal comfortably with my relative's mood."
- Staff told us they had received training, however there was no oversight of training records in the office, so we could not review this.
- Staff told us they received an induction before they started working with people. They told us they completed training online and then had the opportunity to shadow more experienced staff so they could get to know the people they were supporting.

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.

- The provider was currently not supporting anyone who could not consent to their care.
- Staff told us had received training in this area and were able to demonstrate a verbal understanding of the requirements of the Act.

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

● When needed staff offered support to people at mealtimes. One person told us, "The carers make me a microwave breakfast from food in the fridge. They do me a sandwich for the evening. I have 2 meals a day. They ask me what I'd like to eat. They will make me a drink, or I'll make one for myself".
● There were care plans in place that were related to people's dietary needs. This included the support people would need and their preferences including their likes and dislikes.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Although the provider was not responsible for managing people's health, when concerns had been identified we saw action had been taken. For example, 1 person had been referred to the district nurses for support with their wounds. A relative told us, "The carers let me know if they have any health concerns and who they have reported them to. They phoned about [an issue with my relative's health] and I got in touch with the doctor. It cleared up after the antibiotics."
● People's oral health was considered and there were plans in place for this.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection since this service has been registered with us. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care

- Records did not reflect how people had been involved in decision making. Although people and relatives told us they were involved with the process, it was not always reviewed in a timely manner. One relative told us, "A care plan was made. It was a three-way discussion. There is a copy with us. Now a review is needed since my relation has got worse."

Respecting and promoting people's privacy, dignity and independence

- As people were left without support as calls were missed, we couldn't be assured their needs were respected or fully met.
- When calls were attended, people's privacy and dignity was encouraged and promoted. Staff gave examples of how they supported people. One staff member told us, "We encourage people to do what they can and just give a helping hand when needed."
- Staff told us how they encouraged people to do tasks for themselves, to ensure they remained independent. One person said, "I do as much for myself as I can. My motto is if I can do it then I'll ask myself to do it. I wash my front and they (carers) do my back."

Ensuring people are well treated and supported; respecting equality and diversity

- People and relatives were happy with the staff who supported them. They felt they knew them well and were caring towards them. One person said, "The carers are polite and helpful with me." A relative told us, "They (carers) show sympathy, understanding, are very kind and gentle. Obviously very caring. My relation gets on fine with them. They look forwards to their visits."
- Staff knew people well, including the levels of support, they needed and their preferences.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns
- There was a complaints policy in place, however the nominated individual was not aware of this, and this was not always followed.
- We saw 3 complaints in a file. These had not been responded to in line with the providers policy. For example, the complaints were not dated, no acknowledgement had been sent to the complaint, no investigation had taken place and there were no outcomes that had been shared with people.
- People and relatives told us they knew how to complain and when they had raised concerns with the care staff action had been taken. One person told us they had raised concerns about an experience they had and were still awaiting a response from the office.

Complaints were not responded to in line with the providers policy. This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

End of life care and support
- No one was being supported with end-of-life care at the time of our inspection. There were no references to this in people's care records, to show this had been considered, such as preferences or future plans.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
- People and relatives told us the service was responsive to their needs. One person said, "I can change my visit time anytime. I ring them and they fit in with me." A relative told us, "We've cancelled some visits if we're going out or asked them to come later. They (office) always try to accommodate us."
- People and those important to them felt they were involved with their care and the reviewing of this. A person told us, "The company office visited and talked about my care needs and wrote it down. It was put onto a computer. The carers have a book. They asked me what I'd like and what I could do. I did sign a form."
- Care plans that were in place were reflective of people's likes and dislikes and preferences.

Meeting people's communication needs Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
- The Accessible Information Standard was considered. The manager and staff were aware of this.
- People's communication needs had been assessed and considered. Plans in place identified how people

communicated and staff we spoke with understood the importance of this.

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

- People were encouraged with their hobbies and interests.
- Staff told us, and people confirmed, they ensured people were comfortable before leaving the call.

Inadequate

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- There were no quality checks or audits being completed or recorded and subsequently no oversight of the care people received. This placed people at increased risk of harm.
- Systems in place had failed to monitor and make improvements to the quality and safety of care provided to people. There were no systems in place to ensure people had care plans when needed, this included when people had health needs. The systems had not identified that care assessments, care plans and risks assessments were not dated and therefore not reviewed. This placed people at risk of not receiving the care they needed.
- There were no systems in place that monitored people's calls, including the times staff arrived and stayed. When people had missed calls, there were no records of this in the office and no action taken. This placed people at an increased risk of not receiving their assessed care and calls.
- There was no monitoring of medicines. Therefore, it had not been identified that MAR charts were not available for review, handwritten and not always clear, missing dosages, and missing signatures. This placed people at risk of not receiving their medicines as prescribed.
- There were no effective systems in place for the safe recruitment of staff. Staff had not received sufficient pre-employment checks and the provider did not verify their references or employment history. This placed people at risk of being supported by unsuitable staff.
- There were no systems in place to monitor staff training or competency. This included in medicines. Staff did not receive supervision to ensure they were proving safe, effective care. This placed people at risk of being supported by staff who did not have the training or skills to do so.
- There were no monitoring of body maps or daily notes. The provider had not identified that incidents and accidents were taking place and action was not being taken. This placed people at an increased risk of harm.
- There were no systems in place to monitor, investigate or respond to complaints and the providers complaints policy was not followed.
- The system in place to safeguarded people from abuse had failed to ensure incidents were reported to the appropriate body. This meant people were at risk of potential abuse.
- People told us they had given feedback on the service, there was no record of this in the office, so it was unclear if this information had been used to drive improvements.
- The nominated individual told us they had been absent from service and on return had identified that improvements were needed, however no action had been taken to resolve the concerns and there were no action plans in place.

Systems in place were not effective in identifying areas where improvement was required. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● Duty of candour was not understood or followed. When people had made complaints, they had not been responded to. Incidents were not being monitored and therefore appropriate action could not be taken.

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

● We could not be assured that people were consistently supported in a person-centred way as staff were not always given clear, written guidance in how to support people and we could not be assured care records were up to date.

● People were happy with the company and the care they received; However, we received mixed views on the running of the company and the office. One relative said, "There could be more organisation. There are 4 people in the office and carers don't know their visit calls till the night before. They don't have a weekly rota list of carers and times. One manager did come here but I don't know the owner or their name." Another person told us, "No complaints about the running side of it. They are on the ball. They haven't forgotten me. I've met 2 of the managers."

Working in partnership with others

● The service worked with other agencies, where they had identified concerns to ensure people received the care they needed.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from potential abuse as incidents were not always recognised, investigated or reported so that action could be taken.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not responded to in line with the providers policy.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The lack of pre-employment checks placed people at risk of not receiving support from appropriate staff.

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 17 HSCA RA Regulations 2014 Good governance Systems in place were not effective in identifying areas of improvement.

The enforcement action we took:

We have issued a warning notice in this regulation.