Aquaflo Care Ltd

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Inspection report

Wellesley House
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Ilford
Essex
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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 caring?	**Good**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected Aquaflo on 17 January 2017. This was an announced inspection. The provider was given 24 hours' notice as they are a domiciliary care provider and we needed to be sure the manager would be available to meet us. This was the first inspection at the service since registration in October 2015. Sixty people were using the service at the time of the inspection.

On the day of the inspection the service had a registered manager in post. However, on 24 January 2017, we received an application from the registered manager to voluntarily cancel their registration. We were informed that an interim manager was in place to manage the service. 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.

People were at risk of harm and poor support because risk assessments did not give guidance to staff about how to manage and mitigate risk for people. Support plans were not personalised and lacked detail. The service had not identified the issues we found at the time of inspection.

Staff did not receive up to date training and yearly appraisal of their work and performance. Staff had a basic understanding of the application of the Mental Capacity Act (2005). We found recruitment checks were in place to ensure new staff were suitable to work at the service. Staff had positive views about the leadership and staff culture of the service.

People and their relatives told us they felt safe using the service. Staff knew how to report safeguarding concerns. However, medicines were not always administered safely by trained and competent staff. The provider carried out checks to ensure that staff employed were of good character.

Staff were not always deployed in a way that people received care from consistent, punctual staff. People told us that they got along well with staff that knew them well.

Detailed support plans were not in place and records were not always updated following reviews or changes in people's needs. People were supported by staff if needed, to access support from healthcare professionals where required.

People who used the service and their relatives told us the staff they knew were caring. Staff respected people's privacy and dignity and encouraged them to maintain their independence.

People and their relatives knew how to make a complaint, however these were not always satisfactorily dealt with by the management team.

The service had systems in place to monitor the quality of the service provided through seeking people's feedback and carrying out spot checks. However, these were not sufficiently robust as they had not identified the issues we did, during our inspection and an overview of where improvements were required was not undertaken in order to make improvements.

Staff felt supported by management and staff team meetings were used for staff to speak openly and make suggestions that could lead to improvements.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.
Risks assessments for people using the service did not provide guidance to staff about how to manage risks.

People, their relatives and staff felt there were not enough staff available to meet their needs.

Staff were recruited appropriately.

People and their relatives told us they felt safe. Staff were aware of the safeguarding and whistleblowing procedures and knew how to report any concerns. Staff demonstrated a good understanding of their roles in safeguarding people.

Is the service effective?

Requires Improvement

The service was not always effective.
Staff did not receive sufficient training, appraisals and supervision to support them in their role.

Staff were aware of the principals of the Mental Capacity Act (2005) and understood how it applied. They asked for people's consent before providing care and support.

Staff supported people to access health care professionals when needed.

Is the service caring?

Good

The service was caring.
People told us the regular staff who supported them were caring and treated them with respect and dignity.

Is the service responsive?

Inadequate

The service was not always responsive.
Support plans were not personalised and lacked details about how people wanted their care to be delivered.
Complaints were not consistently listened to and managed by the service.

Is the service well-led?

Requires Improvement

The service was not always well led.
Various quality monitoring and quality assurance systems were in place but were not always effective.
Staff feedback about management was positive.

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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 17 January 2017 and was announced. The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

The inspection team consisted of two inspectors who attended the office on the day of the inspection. After the inspection, an expert by experience made telephone calls to people who used the service and 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.

Prior to this inspection, we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. A statutory notification is information about important events which the provider is required to send us by law. The provider also completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we looked at a range of records about people's care and how the service was managed. We looked at the care records of 10 people who used the service, eight staff files, staff training and recruitment records, complaints logs and quality assurance monitoring records as well as records relating to the management of the service. We spoke with twelve people using the service, the relatives of three people using the service, eight members of staff and the manager.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always managed safely or according to the service's medicines policy. The service's medicines management policy stated that medicine risk assessments should be in place for all people who required assistance with medication in order to protect people receiving medicines from avoidable harm. However, there were no medicines risk assessments in the care records we reviewed. This left people at risk of receiving medicines unsafely.

We found that medicine competency checks to ensure staff were able to safely administer medicines, were not always completed properly. This resulted in staff assisting people without the necessary skills and competence required to manage complex medical conditions. For example, one competency assessment stated that the staff member was competent even though they had failed to achieve the required score as stated on the competency assessment record. This left people at risk of being supported to take medicine by staff without sufficient knowledge. We spoke to staff about medicine training and they told us they had received training when they started almost two years prior to the date of inspection. One staff member said "We were shown how to give the medicine through the PEG, but not sure what it is for." Another said "We give it [medicine] but the family know more about it." We asked for medicine administration records. We were given two records and both had several unexplained gaps on the medicine administration record. This meant that medicine records did not always accurately reflect if people had taken their medicine as prescribed.

Risks to people were not always assessed. Records we reviewed showed risks such as choking, falls and nutrition were identified. However, there were no documented assessments completed in order to outline the steps staff needed to take to manage the identified risks. Staff supported people with several complex care needs such as Percutaneous Endoscopic Gastrostomy (PEG- a tube inserted to the stomach to enable people to receive nutritional support), tracheostomy (a tube to enable breathing) care, urinary catheters (tube to drain urine from the bladder) and swallowing difficulties. However, we found that risks were not fully assessed and staff were not trained and did not fully understand people's conditions and needs. When we asked staff to explain what health conditions some of the people they supported had, they could not always explain beyond physical tasks what they would look out for when dealing with people with specific medical conditions. This left people at risk of receiving unsafe and inconsistent care from staff who did not have the necessary skills or competence to provide safe care.

Two out of six staff told us they did not always have enough staff for double up visits. This was confirmed by some people using the service and log in and log out sheets we reviewed. There were two confirmed occasions where a double up visit was completed by one staff member instead of two. This left people at risk of unsafe care as appropriate moving and handling procedures were not followed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff demonstrated an understanding of safeguarding people and had attended relevant training. They were aware of the reporting procedures in place including the use of accident and incident forms. We reviewed safeguarding records and found action had been taken to protect people from avoidable harm, identified

within the safeguarding record we reviewed. Appropriate steps had been taken to ensure staff were aware of the reporting procedures including flow charts displayed within the office with contact details of safeguarding departments and agencies.

Staff were aware of the need to keep key codes safe and the procedure to follow if they did not get a response on arrival at people's homes. They had attended training on how to respond in emergencies such as falls. They told us they would wait with people until an ambulance had arrived and call the office and next of kin. There were two recorded missed visits and five recorded late visits since January 2016. We found that these were clearly documented with remedial action taken such as speaking with staff concerned and monitoring to ensure they did not miss any subsequent visits.

There were robust recruitment procedures in place to ensure that only staff that had undergone the necessary checks were employed. Staff files evidenced that proof of identification, health assessments, two references were obtained before staff could start work. A disclosure and barring check was also completed and refreshed regularly in order to ensure staff were suitable to work within a health and social care environment.

People were protected from the risk of cross infection. Staff had attended training and were aware of infection control principles and guidelines. They told us they always ensured equipment was clean before use. Staff had access to personal protective clothing and told us that they would always collect this at the office. One member of staff said "Yes we have gloves and aprons. They are left in people's home and we can also collect from the office if needed." They understood their responsibilities in terms of preventing the spread of infection by means of hand washing and use of protective clothing.

Requires Improvement

Is the service effective?

Our findings

The service was not consistently effective. We found shortfalls in the staff appraisal system, training, skills and competence of the staff. Although there was an appraisal system in place we found only one out of the four staff due an appraisal had been completed. Six out of the eight staff files we reviewed confirmed that annual training was overdue. When we asked the registered manager about this they said training was completed quarterly. However, some staff training had been due since October 2016 and no action had been taken to ensure staff were trained or competent in those areas. Similarly the registered manager was not able to provide any specialised training records for staff, in areas such as tracheostomy care and PEG care despite this being asked for at the beginning of the inspection. The training matrix (a record of all staff training) was not up to date as three staff who were working the week of inspection did not have any record of training completed on the matrix.

Staff we spoke with were not aware of the full extent of the complex needs of the people they looked after. We asked staff about how they managed PEG feed and the PEG site. They could not explain beyond setting up the feed and the flow rate. We asked staff if they knew what to do if someone was choking. They could not always explain the procedure, although they cared for people assessed at risk of choking. The above concerns did not always ensure that people were cared for by staff who were provided with relevant specialist training and were competent to support people safely, thereby leaving people at risk of inappropriate care.
This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 Act 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. We checked whether the service was working within the principles of the MCA.

Staff told us they had attended MCA training and the training records confirmed this. When asked about consent to care and treatment, staff said they would seek people's consent before providing care and support. They would never force people to do anything they did not want to, but would try and encourage people or come back later if unsuccessful. However, staff understanding of the MCA was variable. Only two of the six staff we spoke with showed insight into what capacity meant. The others were not sure with responses like "We do everything for them as they are totally dependent. Where we don't know we ask [relative]." Another said "They can't speak so we help as best as we can." We recommend the service provide refresher MCA training to all staff so that they are clear about their role and responsibility under the MCA.

Before staff started work, they completed an induction program which included shadowing and completing a workbook with the 15 care standards outlined in the care certificate. They also shadowed experienced staff. In addition spot checks and supervisions were completed regularly in order to ensure staff were delivering care according to the care plan.

When required staff were aware of people on special diets. They told us how they supported people to eat and maintain a balanced diet. Some people had food and fluid charts in place to monitor their dietary intake. Staff also completed other charts as required such as fluid and bowel charts. They informed the district nurse or GP if there were any concerns.

Good

Is the service caring?

Our findings

People who used the service and their relatives were mostly complimentary about the staff that they knew and the care and support they received from them. One person told us "Sixty per cent of the carers I have walking through the door from Aquaflo are definitely kind and caring." Another person said "When the carers come in a good mood they are kind and caring." Relatives told us the staff were kind and caring. One relative said, "They look after my mum well. They are like friends and companions." Another told us "The carers pay attention to [my relative's] needs. They are lovely people."

People told us the care staff treated them with dignity and respect and communicated with them in a way that made them feel comfortable. They told us they were given privacy when they needed it and the regular care staff understood their changing needs and were flexible in helping them to meet these needs. One person said, "The carers definitely would not do anything that made me feel unhappy. They don't make comments about my body. They are very friendly and I can have a bit of banter with them." Another person told us, "I am mostly treated with dignity and respect. There were a couple of staff I thought were being disrespectful. I would like to have people who have basic common sense." Staff ensured that people felt they were treated with dignity and respect and were flexible in the way they offered support to people.

Staff told us how they ensured people maintained their independence while using the service. One staff member said "We encourage people to do as much as they can for themselves and offer support where needed." People confirmed that the care staff encouraged them and worked in a way that enabled them to maintain their independence.

Inadequate

Is the service responsive?

Our findings

The service was not always responsive. People who used the service did not have person centred care plans (support plan), following an assessment of their needs and commencement of the service. Person-centred planning is a way of helping someone to plan their support, focusing on what's important to them as an individual. For example, developing a care plan for different areas based on people's specific needs such as healthcare, support with medicines and personal care.

The care plans we reviewed consisted of a list of tasks to be undertaken by care staff within a given time. They did not consistently record people's preferences about how they wished to be supported. We saw that the service supported people living with dementia and health conditions such as diabetes, catheter care, tracheostomy care and PEG care. However, the files we looked at did not contain a personalised care plan that set out people's specific needs and how the staff were to meet their needs in an individualised manner. For example, for a person living with dementia, there was no reference about the signs and symptoms which the person may display or guidance about how staff should communicate with them in a way they understood, in order to provide the care they needed. Another file stated that a person who had diabetes, required assistance with catheter care, monitoring of pressure areas, assistance with application of splints and support with personal care, as well as medicine administration. They required support from two staff. Their support plan identified a list of tasks to be carried out but did not give details to staff about how to provide individualised care to this person in a way that met their specific needs. However, another more recently completed support plan had detailed information about a person's preferences, for example, in relation to washing and food choices.

The service provided care and support to people with continuing health care packages. We found that the support plans did not consistently record sufficient detailed information about people's individual needs and how to meet these. There was a risk that care would not be given in a consistent way, in the way people preferred. This is particularly important for people who have complex health care needs and people living with dementia, whose health may deteriorate and they can no longer express views about their care. This also meant there was a risk that some information about people's needs did not get reviewed, because staff did not always document relevant information. Some people who used the service told us they had support plans and others were unclear about this and did not fully understand the process.

We received mixed responses from people and their relatives about whether they received the care that they needed. Some people were consistent in their feedback that the service failed to provide personalised care as staff could not be relied upon to arrive at the scheduled times. One person said, "They are not coming when they are supposed to come. For two days they didn't give me dinner. When you call them [the office] they never return your call. I had to call my neighbour to help me." Another person said, "You can't rely on them to come every day." Another person told us, "The staff all come from different areas. The staff spend a lot of time travelling. I have been onto Aquaflo about this problem. They can't provide male carers. There is no real continuity. I want a male carer and I want regular times. The carers are coming at irregular times depending on who is coming. On a couple of occasions the staff have not been able to come and they have not rung the office. Sometime I've been without care. Aquaflo has got some good staff, but they can't keep

them."

Another person told us, "I have not been very happy with the care for many reasons. The carers log on and vanish after a while. I should keep a check on their times. They are not staying as long as they should. Some are more helpful than others. The chap I've got seems helpful enough but he gets everything wrong, even when I write it down. I write down the details. He may not understand what I'm saying as English is not his first language. A carer might say that it's not on their care plan but I've not had a copy of the care plan so I don't know what's on it."

People told us that staff did not always stay the required amount of time. One person told us, "I have different carers coming all the time. I want the same person. They are not giving the full time. They are not staying long enough. They should give me thirty minutes, but they stay five to ten minutes." Another person said, "They come an hour too early. I have complained to the manager but it goes in to one ear and out the other. I don't mind if they come late for one day but sometimes it is over and over." We looked at signing in and out times for six people and found that staff did not always stay for the duration of the visit. On some occasions staff were leaving up to 22 minutes before their visit was scheduled to be completed.

Assessments of people's needs and the subsequent development of personalised care plans which give guidance to staff about people's specific care needs and how best to support them, are key requirements in ensuring people receive care and support in accordance with their identified needs and wishes. All of the above concerns constitute a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives said that they knew who to speak to if they had any concerns or complaints. The complaints policy and procedure was available in the folders in people's homes. The policy gave information about who to contact if a person was unhappy with the provider's response. However this only included the Care Quality Commission (CQC) and did not list any other agencies they can contact, such as the local authority or the Local Government Ombudsman. People told us they contacted the office if they wished to make a complaint. One person said, "I would phone the office, they usually sort it out." However, most people told us that contacting the office with complaints was not always an effective way to achieve change. They told us, "Every time I phone to complain they ignore it." Another said, "Aquaflo flat out ignore my concerns. Someone would come for one visit but it is not followed up. If it is followed up, I can guarantee it is passed to another manager who does not know the previous history. They would say that they don't know about the grievance because they've just had my case. They start with a blank canvas every time."

Records showed formal complaints were dealt with by the manager who had completed investigations and taken action against staff where this was appropriate However, some people told us they had made complaints, but had not seen any changes as a result. One person told us "I've already spoken to them about the times they arrive, it doesn't make any difference."

We discussed the handling of complaints with the registered manager, who told us information about how to complain was given to people when they started to receive support from the agency. We saw that complaints received were logged monthly and most related to late or missed calls and care workers not staying the full length of time. The manager told us that they followed their complaints handling policy. Some people told us they had made complaints, but had not seen any changes/improvements as a result. We found that the registered manager had not completed audits of feedback collected and complaints. We asked to see evidence that learning had taken place following complaints, but this information was not available. This meant it was not clear that the complaints process and feedback mechanisms had led to the service learning from people's experiences, concerns and complaints. Therefore the provider had not

effectively operated a fully accessible system for identifying, receiving, recording, handling and responding to complaints. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

We received mixed responses from people and relatives about whether they felt the service was well-led. A relative commented, "Overall I am happy with everything. There are no problems." However, people who used the service commented "Nothing is organised from top to bottom" and "Aquaflo should be good at communication but the communication between their staff and clients is appalling. They are less willing to adapt to change."

Although there was a registered manager in post at the time of inspection, they had resigned from the service at the time of writing this report. An interim manager was in place.

The registered manager sent surveys to people, relatives and staff to seek their views and opinions. We saw questionnaires which had been sent out or returned from this year. The service had received mixed feedback from people and relatives. For example, a relative had commented "Even though from time to time the personnel that attend to my mother change, they are mostly of good quality with high standards." People who used the service commented "Mainly happy with the carers." A number of comments were received where improvements were needed. For example, "Continuity of personnel especially for my mother who has dementia", "Improve communication when carers are running late", "Both carers should come together. Time keeping", and "Improve dealing with the office."

The agency had systems in place to monitor and review the quality of the service. This included regular monitoring of the quality of care. However, the systems did not always identify where there were areas for improvement such as those identified during this inspection. For example, failure to manage risks and respond to feedback.

Therefore, although the service had quality monitoring systems in place, they did not have a an overview of where improvements were required and action was not taken in a timely manner to make improvements. The above constitutes a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a central log of accidents and incidents which meant that the registered manager could identify patterns, such as where people had suffered multiple falls, bruising or the risk of developing pressure ulcers. This meant a referral could be made to a healthcare professional for appropriate support.

Staff told us that they felt supported by management and they created a positive team working environment. Monthly staff meetings were held. Staff told us that they could raise issues or make suggestions to management. The manager told us that minutes of staff meetings were e mailed to them.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not always ensure that people who use the service received person centred care and treatment that is appropriate and meets their needs. Regulation 9(1)(a)(b)

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were not in place to ensure the proper and safe management of medicines within the service. Appropriate measures were not followed to ensure that risks were consistently assessed and action taken to mitigate such risks. Regulation 12(1) (2) (a) (b) (g).

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had not effectively operated a fully accessible system for identifying, receiving, recording, handling and responding to complaints. Regulation 16 (2)

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance

The provider had not ensured that sufficient quality assurance and governance systems were in place to recognise and make any required improvements in the service. Records were not always maintained effectively. The provider did not always act on feedback received.
Regulation 17 (1) (2).

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure sufficient numbers of suitably qualified, skilled, competent and experienced staff were deployed or that staff received appropriate support, training and appraisal. Regulation 18(1) and (2) (a).