Morepower Limited

AQS Homecare - Hampshire East

Inspection report

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Hampshire
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13 April 2018

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

Summary of findings

Overall summary

This inspection took place on the 12 and 13 April 2018 and was announced. This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults and younger disabled adults. Not everyone using AQS Homecare receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

At the time of our inspection a registered manager was not in post. The previous registered manager had left the service on 7 March 2018. The service was being managed by one of the provider's locality managers who was planning to register with the Commission. 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. We have therefore referred to the locality manager as 'the manager' in this report.

At our last inspection of the 7 and 8 March 2017 we found a breach of Regulation 18 (Registration) Regulations 2009 Notification of other incidents. This was because the provider had failed to notify the Commission without delay of any abuse or allegations of abuse in relation to people who use the service. At this inspection we found the provider had failed to make the required improvements and this Regulation had not been met.

This inspection was the third inspection since the service had been registered. The previous two inspections identified failures to meet the fundamental standards of care and both inspections awarded a rating of overall requires improvement with each key question rated as requires improvement. At this inspection we have continued to find that this service is not meeting fundamental standards and has been unable to improve their rating in any key question or overall. This demonstrates a lack of understanding of the principles of good quality assurance, a lack of effective quality assurance, a lack of learning, reflective practice and a lack of drivers for service improvement.

Whilst a system of audits was in place to monitor and assess the quality and safety of the service, these were not effective in identifying and addressing all of the concerns we found.

People told us they felt they were safely cared for by the provider's staff. However, risks associated with people's needs had not always been assessed and when they had risk management plans did not always provide sufficient guidance for staff to ensure they minimised these risks. People told us they were supported appropriately with food and drinks were applicable. Risks to people from eating and drinking required more detail to ensure safe guidance was available for all staff to follow.

Incidents were recorded, acted on and monitored to address safety issues and prevent a reoccurrence. Staff

were aware of their responsibilities to report concerns and protect people from abuse. Action was taken when safeguarding concerns were identified but people's care records were not always updated following these to reduce risks for people.

People's records did not always evidence a mental capacity assessment had been completed to determine if the person had the capacity to agree to their care and treatment. We found inconsistent and incomplete information in people's care plans about their capacity to consent. Not all staff were aware of the principles of the Mental Capacity Act (2005) and how these should be applied to support people to have maximum choice and control of their lives.

At the time of our inspection there were enough staff to meet people's needs. However, people told us they did not always receive their care in an informed, consistent or timely manner that met their preferences. The manager told us local authority commissioning arrangements meant care calls were needs led and this meant people could not always have their preferences for call times met.

People and their relatives told us the care they received met their or their relative's needs. Some care plans we reviewed contained clear information about people's needs and how these should be met by staff. Some people's care plans did not fully reflect their choices, preferences, personal history and important information to ensure staff would know how to provide person-centred care when they did not know the person well.

People and their relatives told us they were supported by kind and caring staff who respected their privacy and dignity. Some people said they did not always experience a caring response from office staff and told us they did not always feel listened to. People were not always able to make decisions about the preferred time for their care due to commissioning arrangements. People were not always given information about when to expect their care call and who would be delivering their care. This meant people did not always feel involved, valued and respected by all staff.

The management of people's medicines required improvement. Medicine administration records (MARs) were not always completed to show people had received their medicines as prescribed. Care plans did not always include accurate and up to date information about people's medicines. The provider was taking action to improve this for people, however, the provider required more time to embedded improvements into practice to ensure people's medicines were safely managed.

People told us they were aware of how to raise any concerns or complaints with the provider. We saw records which showed complaints received had been responded to. However, people did not feel their concerns were always sufficiently heard or responded to. Whilst records showed actions had been taken in response to complaints received, the system in place did not evidence trends were monitored to identify learning which would drive improvements in the service people received. We have made a recommendation about improving the management and learning from concerns and complaints.

Not all staff had completed training in line with the provider's requirements. This meant people could be supported by staff without the knowledge or skills to provide effective care. Following the inspection the provider confirmed all staff had been booked to attend any outstanding training.

People's needs were assessed when their package of care commenced and this included their needs in relation to the protected characteristics under the Equalities Act 2010. The provider had policies and procedures in place to guide staff in providing a service which took account of people's diverse needs and respected their beliefs and lifestyle choices. Staff acted promptly to support people with their healthcare

needs. The provider had an 'end of life care' policy to support staff in providing appropriate care and treatment when supporting people approaching the end of their life.

A new manager was in post and staff spoke positively about their leadership. Staff were confident any concerns raised would be acted on by managers and told us the culture of the organisation was open and transparent. Staff were supported to understand their roles and responsibilities through supervision, spot checks and team meetings.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the (Registration) Regulations 2009, we have made one recommendation. You can see what action we told the provider to take at the back of this 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 associated with people's needs were not always assessed and plans to mitigate these risks developed and recorded.

The management of people's medicines required improvement to ensure people were safely supported with their medicines.

Overall there were sufficient staff to meet people's needs. However, people told us their needs were not always consistently met in an informed, timely and reliable way.

People were protected from the risk of abuse, because staff understood how to identify report and address safeguarding concerns. Concerns about people's safety were acted on.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff were clear about the principles of the Mental Capacity Act (2005) and how to apply these in their work to support people to have maximum choice and control of their lives. There was inconsistent and incomplete information in people's records relating to their capacity to consent to decisions made about their care.

Not all staff had completed up to date training to support them in carrying out their role effectively.

People were supported to access healthcare as required.

People's needs were assessed and the assessment took account of people's diverse needs and protected characteristics under the Equalities Act 2010.

Is the service caring?

Requires Improvement

The service was not always caring.

People did not always feel they received a caring response from

office staff. People did not always feel involved in decisions about their care, listened to or informed about changes by the provider.

Staff we spoke with were knowledgeable about the people they supported and how they preferred to be cared for.

People told us they were treated with kindness by caring staff. People's rights to privacy, dignity and choice were respected by care staff.

Is the service responsive?

Requires Improvement

The service was not always responsive

People's care plans did not always reflect their choices, preferences, personal history and important information to ensure staff would know how to provide person-centred care when they did not know the person well.

Processes were in place to document, investigate and respond to complaints. People told us they did not feel their concerns were always listened to or responded to by the service. Themes from complaints and concerns were not effectively used to drive improvements in the service.

Although nobody using the service was currently receiving end of life care at the time of our inspection. An end of life policy and procedures were in place to guide staff on how to support people appropriately during this time.

Is the service well-led?

Inadequate

The service was not well-led.

Improvements had not been made following our last two inspections.

Notifications about allegations of abuse continued not to be submitted to CQC as required by the Regulations. Actions to monitor the submission of notifications had not been effective.

Quality assurance processes were in place to monitor and assess the quality of care people received. However, these had not been effective in identifying all the concerns we found or in driving continuous improvements in the service.

Staff spoke positively about the leadership of the service and told us they were supported in their role and responsibilities through

supervision, team meetings and spot checks.

AQS Homecare - Hampshire East

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 12 and 13 April 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because the location provides a domiciliary care service and we needed to be sure the staff and people we needed to talk to would be available.

The inspection was carried out by two adult social care inspectors. Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events which the service is required to tell us about by law. Prior to the inspection we reviewed information included on the 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. We used this information to help us decide what areas to focus on during our inspection.

Inspection site visit activity started on 12 April 2018 and ended on 13 April 2018. We visited the office location to see the manager and office staff; and to review care records and policies and procedures. We carried out telephone interviews with nine people who used the service, two people's relatives and a staff member. We visited four other people who received a service from the provider in their own homes and observed interactions between people and staff. We sent out 50 questionnaires to people who used the service and we received 20 responses. We received six responses from people's relatives and friends. We did not receive any responses from staff or community professionals. We requested and received feedback on the service from a local authority commissioning officer. We spoke with the locality manager, senior care coordinator, two care coordinators, the referrals coordinator and six care staff. Following the inspection we received

information from the operations manager.

We reviewed records which included 13 people's care plans, daily records and medicine administration records (MARs) staff training, recruitment, supervision records and staff meeting minutes. We also looked at records of incidents and complaints along with records relating to the management of the service, such as quality assurance audits and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

95% of the people and all of the relatives who responded to our questionnaire agreed with the question 'I feel safe from abuse and/or harm from my care and support workers.' All the people we spoke with told us they felt safely cared for by the provider's staff with one exception. This person felt staff were "Safe 99% of the time" but went on to say that a new staff member had not given care as planned. People and their relative's comments included "I feel safe because they are very good." "Well, she's a very caring person, a qualified nurse, absolutely wonderful. I feel very safe in her hands."

Risks associated with people's needs were not always assessed and plans developed to mitigate these risks. We found examples where risks to people had not been documented as assessed or where they had been assessed, plans to mitigate the risks contained insufficient guidance to ensure people's safety. This included risks associated with diabetes, safeguarding concerns, risks associated with choking and risks from falls. For example; a person with a health condition that we were told caused them to be at risk of choking did not have a clear detailed risk assessment in place to provide clear safety guidance for staff.

Detailed risk assessments and actions to mitigate risks were not in place for two people who had behaviours that may challenge others. Another person with complex needs required support with their mobility by two staff members. However, at times we were told the person could be safely supported by one member of staff. There was no documented risk assessment, by an appropriately trained and competent professional, to show this had been assessed as safe for the person. Whilst we saw the service had sought agreement from the person and social services to this arrangement, we did not see that a risk assessment was in place to support this decision and mitigate any risks to the person. Whilst staff we spoke with were aware of these risks and the care coordinators had a good understanding of people's needs and verbally communicated these to staff, if a staff member needed to refer to written guidance this would not be available to them. This posed a risk that staff could fail to take the appropriate action to ensure people's safety because risks associated with people's needs had not been appropriately assessed and plans developed which would minimise these risks.

Staff we spoke with understood their responsibility to protect people from abuse and were aware of how to report any concerns. Information about reporting abuse was available to staff in the staff handbook. Staff gave us examples of when they had reported concerns and were confident coordinators and managers would act upon concerns. We explored the management of safeguarding incidents with the care coordinators and the manager. We saw they had taken the appropriate actions in response to concerns raised. People were protected from the risks of abuse because staff understood the signs of abuse and the actions they should take if they identified these.

However, people's records did not always clearly reflect the risks to people and plans to safeguard people from further abuse following an allegation. We were told by a care coordinator that staff were updated on these issues verbally. The provider's safeguarding policy referred to the need to ensure the 'person's care plan was reviewed and amended in line with any protection plan to ensure the person is properly supported and the risk of further abuse is prevented or minimised'. This meant people may be at risk of being

supported by staff who were not aware of their protection and safety needs.

A failure to ensure risks for people had been effectively assessed and plans developed to mitigate these risks was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives who responded to our questionnaire did not always agree that staff arrived on time or stayed for the agreed length of time. We received a mixed response from the people we spoke with. Some people were satisfied with the timing of their calls, the consistency of staff and the communication from staff when they were running late. Other people expressed frustration with late calls and a lack of consistency in the care staff who visited them. Some people said they did not always know who was coming to provide their care or the time they were coming. This was important to some people because regular care staff knew and understood people's needs well and provided a consistency of care which they valued. People's comments included "I just have to go to bed early if they come at 7pm instead of 8.30 or 9pm, and read or watch TV in bed." Another person said, "Sometimes they come in late and say they are so tired, exhausted, which I don't want to hear every time. "One person said "They do all that needs to be done and always stay the extra 5 mins to finish anything off." Three people told us that care staff leave 'early' and asked them to sign that they have been there the full time before completing their calls. We informed the manager of this who told us they would take action to address this with staff.

People told us they did not always receive a reliable service at the time they preferred. Unless people's calls were time specific, for example when people required medication at a particular time, people were usually allocated calls within a time range subject to their needs. The manager and care coordinators confirmed there were sufficient staff deployed to meet people's needs. However, the local authority commissioning arrangements meant that people were prioritised according to need and this could impact on the timing of calls and consistency of staff for people. This was in order to increase the capacity of staff to ensure people who required care at a specific time could be prioritised and other calls could be prioritised based on people's risk level to enable staff to deliver care more flexibly.

People did not report they had experienced any harm as a result of the arrangements in place. Overall there were sufficient suitably qualified staff to meet people's needs. However, the arrangements in place meant people did not always receive their care in an informed, consistent and timely manner that met their preferences.

No one we spoke with had experienced a missed call. The manager told us this was "Very rare" and would be flagged either by the person or a subsequent carer. The senior care coordinator told us calls were planned each week in advance so that any gaps could be covered and contingency plans were in place to ensure people received their care, for example; office staff were able to cover for care staff in the event of an unplanned absence or leave.

Procedures were in place to check that people were protected from the employment of unsuitable staff. These included a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with people who use care services. Identity checks and character references were obtained and candidates attended an interview to assess their suitability for the role. Applicants were asked to complete details of their full employment history, we found two examples of gaps in people's employment history which were unexplained. There was no record these gaps had been explored at interview. We have asked the manager to ensure all gaps in employment are explained and recorded to ensure the suitability of staff.

People who were supported by staff with their medicines told us this was well managed. A person said "I have dysphagia and the carers watch me take all my medicines to make sure I don't choke". Another person said "I have a blister pack. The carers open the pack for me and put them in a pot. I look at them to check and put them in my mouth."

We reviewed people's Medicines Administration Records (MARs) and found that staff were not always completing these to evidence people had received their medicines or the reason why not. In five of the records we reviewed, we found numerous gaps in the recording of people's medicines on their MAR. It is important to accurately record the administration of people's medicines to check people have received their medicines as prescribed and any missed doses can be monitored and acted on. The provider's medication policy clearly explained the requirement for care staff to fully complete the MAR when people's medicines were taken or not.

We also found that care plans did not always contain accurate information about people's medicines. For example; for a person who was supported with topical medicines (creams applied to the skin), their care plan did not contain any information about this. Another person told us care staff applied creams 'most days'. However, when we looked at this person's care plan, this was not identified as a risk or need. A district nurse visited whilst we were with this person and commented that the person's leg was very 'dry'. There was a risk this person may not receive the care they required without clear guidance for staff. For another person we found their MAR stated they were now administering their own medicines; however their care plan stated care staff provided support with dispensing their medicines in a cup for them to take. This was considered to be staff administering medicines in the provider's policy.

We spoke to the manager about the failure to accurately record the administration of people's medicines. They told us they were aware this needed improvement and action was being taken to address the poor recording of medicines with staff. This included staff supervision, training and review and audit of records associated with people's medicines.

The failure to ensure the safe and proper management of people's medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed staff using protective personal equipment when providing care for people. This included the use of aprons and gloves. This supported people to be protected from the risk of infection. Staff completed training in Infection control and records showed this training had been completed.

All incidents were recorded on to a call logging system which meant they could be seen and shared by managers and other relevant staff to monitor progress. Incidents were updated with actions taken until concluded. For example, we saw the senior care coordinator was investigating an incident concerning a medication error. This meant risks to people from incidents were monitored and action was taken to address safety issues and prevent a reoccurrence.

Requires Improvement

Is the service effective?

Our findings

We received a mixed response from the people and relatives we spoke with and those that completed our questionnaire, to the statement 'My care and support workers have the skills and knowledge to give me the care and support I need'. People's comments included "Main carer yes, some of the younger ones not so good, not so experienced in personal care. A girl was a bit slap dash, more worried about getting to the next client" and "I do question them, They don't seem to be getting any training, think they should, especially the younger ones." Other people told us "Yes, my carer connects my catheter, creams my skin and observes for pressure sores" and Yes, they are so good, very caring. They worry about me. If I have any problems they sit and listen."

New staff were required to complete the Care Certificate. The Care Certificate is the industry standard which staff working in adult social care need to meet before they can safely work unsupervised. Induction of new staff included the completion of a knowledge based workbook, and practical competency assessments. Staff we spoke with told us they were supported by their line managers through supervision and appraisal and we saw the records that confirmed this. Spot checks were carried out by care coordinators to assess staff competency in a number of areas including; treating people with dignity and respect, supporting independence and choice, manual handling and medication.

We reviewed the training records for all staff and saw not all staff had completed training in line with the providers requirements. For example; not all staff had completed their annual refresher safeguarding training in line with the provider's safeguarding policy. In the records we reviewed 17 staff out of 34 had not completed their refresher training and seven staff had not completed safeguarding training. Nine staff required refresher training in moving and handling and 16 staff required refresher training in medication. Only eight staff had completed training in food hygiene, fluids and nutrition. This meant there was a risk people would be supported by staff without the skills and knowledge to meet their needs effectively. Following the inspection, the provider's operations manager told us that training had been booked for all staff with training gaps.

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.

People we spoke with told us they were asked for their consent before care was provided, whilst some people, who completed our questionnaire, told us they were not always involved in decision making about their care and treatment. Not all of the staff we spoke with were able to tell us about the MCA and how they used the principles of the MCA in their work with people. One care coordinator told us they "Had never had to deal with the MCA and I am not sure when to carry out an assessment." Another staff member said they were "Not sure" about the MCA and the referrals coordinator told us they had not completed training in the MCA and relied on the information given by the local authority at referral regarding people's capacity to

make their own decisions. We were concerned people's rights under the MCA may not be upheld because not all staff, including key staff involved in the assessment and supervision of staff, understood the principles of the MCA and how these should be applied in their work with people.

People's records did not always evidence their mental capacity to agree to their care and treatment had been assessed when they lacked the capacity to make some decisions. In one person's records it stated the person did not have capacity. Their care plan was signed by another person but it did not indicate who this person was. Their records stated that a relative had Lasting Power of Attorney (LPOA) however, the records did not state for which type of decisions this person had this legal authority. The referrals coordinator told us they did not routinely ask to see proof of people's legal authority to make decisions on their (people's) behalf. In another person's care plan it was stated the person did have capacity but went on to state in the care plan that their relative had responsibility for decisions about their care and their care plan was signed by their LPOA. The person had signed their risk assessment but this contained minimal information and did not accurately reflect the current risks to the person's health and wellbeing. People can only provide consent for others when they have been given the appropriate legal authority to do so and when the person no longer has the capacity to provide this themselves. Failing to ensure that capacity was assessed and the LPOA was for health and welfare decisions meant people were at risk of receiving care and treatment they had not consented to and was not in their best interests.

We were told by a care coordinator that another person did not have the mental capacity to make decisions. We reviewed their care plan and found this stated the person did have mental capacity. However, the care plan went on to state their relative gives consent to their care. There was no description of the person's ability to provide consent, make decisions or the help they needed to make a decision. No mental capacity assessment had been carried out to determine whether the person had the capacity to agree to the decisions made about their care and treatment.

The provider had a mental capacity policy and procedure in place. Records showed that most staff had completed training in the MCA. The senior care coordinator told us that information about people's mental capacity and the legal authority other people held to make decisions on their behalf had been added to care plans about "One month ago" and records confirmed this. Whilst the provider had systems in place to guide staff in applying the principles of the MCA in their work with people, we found these were not fully effective or embedded into practice. This meant people could be at risk of inappropriate care and treatment that was not based on their ability to consent.

The failure to ensure that care and treatment was always provided with the consent of the relevant person in line with the MCA (2005) was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An initial assessment of people's needs was completed when they started using the service and this included their physical, mental health and social and emotional needs. Needs assessments also included people's support preferences in relation to their religious, cultural and dietary needs. Care plans took into account people's needs in relation to the protected characteristics under the Equalities Act 2010, including age, disability, gender, marital status, race and religion. Information about people's sexual orientation was not included in the needs assessment at the time of the inspection, however the operations manager confirmed this was added to the needs assessment from the 16 April 2018. This meant people's diverse needs were considered in planning their care and treatment.

A diversity and equal opportunities policy was in place which outlined the responsibilities of staff in respecting individuals and valuing diversity. Staff we spoke with showed an awareness of how to support

people with their diverse needs. This included a commitment to respecting people's beliefs and lifestyles and to address discrimination.

People we spoke with told us they had sufficient to eat and drink and that care staff supported them appropriately. People's care plans included the details of people's preferred meals and drinks and the support they required to eat and drink. However, for one person we found their dietary needs were not sufficiently detailed to ensure that when care staff were responsible for the preparation of their food and drinks this would be carried out safely. This person required a soft diet and food and drinks needed to be thickened to a safe consistency to prevent the person from choking. Whilst the person was mostly supported with the preparation of their food and fluids by a relative, the care logs showed care staff did support the person with drinks. The care plan lacked detail about the thickening of drinks and what consistency these should be thickened to as well as lacking guidance on the appropriate preparation of food should this be required. We discussed this with a care coordinator who told us they would address this immediately.

People were supported to access healthcare services when required and people told us staff acted promptly when an urgent healthcare need arose. A person said "Yes, I've had a fall, they came in, took me to hospital and brought me back the next day" and another person said "They (staff) do (act promptly), very much so. They call the district nurses or the GP for me. Any concerns they have, they phone my GP." During a visit to a person's home we observed a staff member discussing a person's symptoms with them and their relative, the carer encouraged the person's relative to call the GP in response to the health concerns noted. Another person said "AQS reported my leg ulcer and referred to DN". Staff took action to address people's health concerns.

Requires Improvement

Is the service caring?

Our findings

Most of the people and their relatives or friends who responded to our questionnaire agreed with the questions 'My care and support workers always treat me (or my relative) with dignity and respect' and 'My support workers are caring and kind'. All of the people we spoke with reported that they thought care staff had a kind and caring approach, and respected their privacy, dignity and independence. People's comments included; " (name of carer) is exceptional, they even swill my false teeth for me and make sure my watch is where I want it" and "The mature ones know us they are excellent and very caring, they go over and above the call of duty, they would wash up or empty the rubbish bins, really good as far as I am concerned". A person's relative said "They always talk to mum in a friendly way, call her by her full name, don't shorten it. They are respectful and don't rush her care."

Whilst people told us they were listened to by care staff, some people did not always feel they received a caring response from the office staff. People's comments included "If my father rings up the office with a query the office staff seem very unhelpful and don't seem to have much care for their clients". "The office don't seem to listen, sometimes I think its false talk. Once I was told a carer was sick, but the next day she turned up and said she wasn't sick but had been sent to someone else." "I told them I want early visits in the afternoon but they haven't listened to that." Another person said "I have spoken to the office about feeling the more experienced carers are preferred." When asked how the office staff responded the person said "Nothing really, they never said they would get it changed or anything like that, they never really commented".

People and their relatives who responded to our questionnaire did not always feel they were involved in decision making about their care and support needs. Some people also told us that they were not always introduced to or informed when new staff were coming to provide their care. A person said " I rely on carers using my key safe so I really want to know who is coming – it could be anybody we used to get a rota but don't now." A person's relative told us "We do know who is coming during the day but we don't know at night". Other people told us they did know the staff who came to support them and saw the same staff fairly consistently. People were not issued with rotas to inform them of whom would be calling and when. The manager told us there was a "Management decision taken last year to stop giving rotas to people, linked to (local authority) commissioning framework so that complaints can be stopped on that basis. We do give an option for people to phone in and get this on request". It is important that people are informed who will be providing their care so their personal security is protected and to enable them to make decisions about their care. In the example we were shown of a service user survey dated 01/10/2017 – 31/12/2017 the results showed people had responded below the provider's target value for 'choice and control' and 'informed of changes'.

People did not always feel respected and valued when they were not involved in decisions, listened to or informed about changes to their care and support.

Staff we spoke with were knowledgeable about the people they supported and could tell us about the things they enjoyed and were interested in. For example; a staff member told us about what a person

disliked and what they 'loved'. This included information about objects of importance to the person which helped to reduce their stress and anxiety. We heard examples of where staff had shown care and kindness by feeding the birds at the person's request, bringing in shopping and helping people to sort out practical tasks in their home. During the visits we made to people in their homes we observed care staff were friendly and compassionate towards people. Care staff engaged people in conversations about their interests and plans and showed concern when people talked about difficulties they faced. The service had received thanks and compliments from people and their relatives that included "The carer was like a breath of fresh air" and "Lovely lady (carer) chatty and willing to do anything" A relative had written to thank the staff for supporting their mother to have personal care which she had been refusing. Spot checks (observations of practice) were carried out by care coordinators to check staff attitude towards people including respecting people's privacy and dignity.

Staff we spoke with demonstrated how they provided care that was respectful and promoted people's privacy and dignity. For example; by providing care in privacy and in the way the person preferred. People told us they received dignified and respectful care.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with all told us the care they or their relative received did meet their needs. People's comments included "Yes, they do everything I ask" and "Yes, I've told them I don't want any gentlemen and don't get any." We found the staff we spoke with were knowledgeable about people's needs.

Whilst we saw some good examples of clear guidance for staff in care plans, other care plans did not always fully reflect sufficient and clear information to guide and support staff who may not know the person well and therefore be able to provide person centred care. For example, for a person who required assistance with a shower, there was nothing in the care plan to describe the person's preferences for how this support was given. For another person living with dementia, there was very little information on their abilities, history and background and preferences. Whilst the care plan included the 'common side effects' of dementia it did not include a description of their personal experience of living with dementia and their abilities to ensure they had as much choice and control as possible. This person sometimes displayed behaviours which may challenge others; however there were no details on the person's care plan to guide staff as to how to support the person should this arise. We have reported in the safe domain that care records did not always include a detailed risk assessment to guide staff on how to support people safely. Dementia eventually impacts on a person's ability to communicate and as such this person may not be able to verbally guide staff as to their abilities and preferences. This makes the need for clearly documented person centred care planning essential. Descriptions of care calls in some of the care plans we reviewed were task focused and did not always include personalised detail to support and guide staff to deliver person-centred care. Care and support plans were not always sufficiently personalised to reflect people's needs and choices.

Most people told us they were aware of how to raise a concern or make a complaint, however 35% of people and their relatives who responded to our questionnaire told us the provider did not respond well to any complaints or concerns they raised. People we spoke with did not always feel their concerns were listened or that they received feedback on how their concerns were followed up, or that they received a satisfactory response. We looked at the records of complaints and saw where a complaint had been recorded; this had been investigated and responded to in line with the provider's procedures. We spoke to the senior care coordinator about how people's and their relative's concerns were managed. We were told concerns were logged onto the system and copies were placed in people's files. We looked at some examples and saw that some actions had been taken to address the concerns raised. A log book was kept of compliments and complaints and this showed action was taken in relation to individual concerns raised. However, these issues were not monitored for trends in order to identify learning and to inform improvements in the service people received. It was not clear if the service had developed as a result of complaints or if any lessons had been learnt. The manager said that they needed to respond to complaints quicker and more effectively and that this needed to be recorded more effectively stating that they, "still need to get better at capturing the conversations". The service user guidebook included information on how to feedback a compliment or complaint, how to contact the branch office and how to contact the CQC or Health and Care Professions Council (HCPC).

We recommend that the service seek advice and guidance from a reputable source about the management

of, and learning from, concerns and complaints.

At the time of our inspection the service was not supporting anyone who was receiving end of life care. The provider had an 'end of life care policy' in place and this described the actions they would take when a person was approaching end of life. This included a review of the person's care needs and the development of a personalised care plan linking with other agencies involved in caring for the person.

Inadequate

Is the service well-led?

Our findings

Most of the people we spoke with told us they thought the service was 'personalised and transparent'. Over 30% of people and their relatives who responded to our questionnaire told us they had not been asked what they thought about the service. Some people said they did not feel they were always listened to and this has been reported on elsewhere in this report.

The service did not have a manager registered with the Care Quality Commission (CQC) at the time of inspection as the previous registered manager had left the service on 7 March 2018. The service was being led by one of the provider's managers in the interim who also managed another of the provider's locations. The manager told us the provider planned to register manager to this post

At our previous inspection on 7 and 8 March 2017 we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009, notification of other incidents. The registered person had failed to notify the Commission without delay of any abuse or allegation of abuse in relation to a service user. The provider had submitted an action plan on 9 May 2017 stating the relevant staff were now clear about the requirement to notify the Commission and this would be monitored and managed by the operations manager. However, during this inspection we found the provider had not submitted statutory notifications in respect of two safeguarding incidents. Whilst records showed the appropriate actions had been taken in relation to the incidents for the safety of people, providers must notify CQC of all incidents that affect the health, safety and welfare of people who use the services, as specified in the regulations. This is in order for the Commission to monitor the safety of the service people receive. Following the inspection the operations manager told us that the manager and the operations manager would oversee the management of all safeguarding incidents. However, this required more time to be evidenced as embedded into practice.

This was a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009. The registered person failed to notify the Commission without delay of any abuse or allegation of abuse in relation to a service user.

There was a system of audits and monitoring at the service. These systems should help registered providers to assess the quality and safety of their service. We saw evidence of audits of the following parts of the service: service user files, complaints, compliments, safeguarding, staff spot checks, staff rotas, staff files and recruitment processes and medication. However, these audits had not identified and addressed all the concerns we found during this inspection. For example, the failure to submit notifications and to ensure risks associated with people's needs were assessed and plans developed to mitigate these; a failure to ensure staff understood and applied the principles of the Mental Capacity Act 2005; a failure to ensure people were involved in decisions about their care and this was planned and delivered in a person centred way; a failure to ensure people consistently felt listened to and respected and a failure to identify trends and patterns from complaints to make improvement for people.

Although there were monthly audits of the medicine records this system had not effectively improved the

recording of administration of people's medication. We saw evidence that this issue had already been discussed in three team meetings but these discussions had not effectively improved the recording. The manager told us that they were aware of the issues with recording on MARs. They informed us that they were going to start a quality monitoring process used in another branch which had been successful in significantly improving recording errors on MARs. The manager said that the quality of the auditing would be improved, close monitoring would continue and errors would be addressed with staff concerned through clinical supervision and team meetings.

The service did gather information from their audits but were not consistently carrying out analysis, learning lessons and driving service improvement overall. The corporate governance policy stated 'Lessons learned will be used in devising preventative actions' but this was not seen in documentation at the service. Staff we spoke with found it difficult to describe lessons that had been learnt which led to improvements; one carer said "Nothing's really changed since I've been there".

We reviewed the service user guidebook which included the service's statement of purpose which sets out the aims and objectives of the service provider in carrying on the regulated activity. It states "We will constantly seek to improve and expand our services for the benefit of the service user". We were shown examples of service user surveys; it was not clear from the records we saw if people's feedback was consistently followed up or if outcomes from these surveys were used to drive improvements. Whilst we saw the results were collated and displayed in a graph, it was not evident the analysis of this information was used to improve the service people received. For example, although people had scored below the provider's target value for 'reliability and punctuality' 'informed of changes' and 'choice and control' in a service user survey dated 01/10/2017 – 31/12/2017, an action plan was not in place to address these concerns and in the feedback we received people continued to report their dissatisfaction with these elements of the service.

This inspection was the third inspection since the service had been registered. The previous two inspections identified failures to meet the fundamental standards of care and both inspections awarded a rating of overall requires improvement with each key question rated as requires improvement. At this inspection we have continued to find that this service is not meeting fundamental standards and has been unable to improve their rating in any key question or overall. This demonstrates a lack of understanding of the principles of good quality assurance, a lack of effective quality assurance, a lack of learning, reflective practice and a lack of drivers for service improvement.

The failure to effectively assess, monitor and improve the quality and safety of the services provided was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a staff survey carried out in 2017 and an action plan was in progress to address themes and concerns that had been identified and improve staff support. For example, regular supervisions were booked for staff.

Staff were supported to understand their roles and responsibilities through staff supervision, regular spot checks and team meetings. We saw records which showed staff had been reminded of the expectations in their role. Staff told us they felt listened to by the manager and understood the expectations of their role.

Staff were positive about the manager. They told us that the manager was "fair" and "always approachable". The manager spoke about trying to promote a team approach and said, "I'd like to think people can approach me". They described the culture of the service as open and transparent and observations on the inspection supported this. When asked about working for the company, one staff member said "I love it". A member of staff who recently left their position wrote they had "Received such a positive experience"

working for AQS Homecare in their resignation letter. Staff felt that the coordinators were "Always very flexible and helpful". However, one member of staff said that they often felt under pressure to take extra calls.

The provider had a whistleblowing policy in place. Staff told us that they were comfortable and confident to raise concerns with the coordinators and manager. The manager told us that concerns raised would be investigated, whistle-blowers would be protected and they would "Not tolerate reprisals". The provider had an Equality, Diversity and Human Rights policy in place. Records showed that when a staff member had been subject to racial abuse from a person using the service this had been acted on to support the employee. The person had been reminded of the provider's expectations that staff would be treated respectfully. A staff member told us "AQS are a diverse company, everybody is welcome. I have never come across anyone who has been judged on their differences. If service users are prejudiced we nip it in the bud."

The manager told us that they attended meetings with the local authority and other care providers to share information and try to improve services for people. The service worked with healthcare professionals, for example, district nurses, in providing care for people. We received positive feedback from a local authority commissioning officer who told us the service engaged well with the local authority and other providers in the area. The service did not inform us of any other links with external agencies or the local community.

The manager said that the visions and values of the service were communicated to staff in team meetings and that they tried to imbed them into training and into how staff communicate with each other in the workplace. Values based interviews were conducted and the manager spoke of the importance of ensuring that people they employed were of good character.

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 Registration Regulations 2009 Notifications of other incidents The registered person failed to notify the Commission without delay of any abuse or allegation of abuse in relation to a service user. Regulation 18 (1)(2) (b)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that care and treatment was always provided with the consent of the relevant person in line with the MCA (2005). Regulation 11 (1)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks associated with people's needs were not effectively assessed and plans developed to reduce these risks. Regulation 12 (1)(2) (a) The provider had failed to ensure the proper and safe management of people's medicines. Regulation 12 (2)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to effectively assess,

monitor and improve the quality and safety of the services provided. Regulation 17 (1)(2)(a)