A & K Home Care Services Ltd

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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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
A&K Home Care Services is a community-based care provider that provides personal care to people living in their own homes. At the time of inspection there were 42 people in receipt of the regulated activity of personal care.

Everyone who received support at the time of our inspection received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
At our last inspection, we found some improvements were required. At this inspection we found failure to improve the overall quality of service people received. We found the providers systems and processes to monitor the quality of the whole service people received continued to require improvements and better recording to embed systems into everyday practice.

At this inspection, we found that although the provider had made some improvements to the service, there continued to be areas of potentially unsafe or ineffective care and support. Some areas identified as improved, had not been improved consistently to minimise people from the risk of harm. We found the provider was now in breach of the regulations because effective oversight of recruitment, medicines management and quality assurance did not meet expected standards.

At this inspection, we found the provider's ongoing action plan described some improvements, but these improvements lacked detail to ensure their sustainability. For example, risks were not always managed safely through appropriate and accurate records or evidenced that the provider had followed their own policies and procedures.

We could not be confident; some people received their prescribed medicines safely. The systems to support safe medicines practices were ineffective. Medicine Administration Records (MAR) did not always correlate with people's care plans. It was not always clear what medicines a person had been prescribed or if staff administered them. People who required 'as and when' medicines did not have a protocol in place to tell staff, when, how and at what dosage these medicines should be given safely.

People were not protected from ineffective staff recruitment checks. The provider had policies to ensure staff were recruited safely and were suitable for their roles by conducting relevant pre-employment checks. However, those policies and checks were not always followed or completed before staff began supporting people. Where staff needed to have a risk assessment to support safe recruitment practices, this was not completed.

We were not confident the provider deployed sufficient numbers of suitably qualified and experienced staff

to meet and support people's assessed needs. Most people and relatives told us staff arrived later than planned and, in some cases, their care calls were cut short. Staff told us they did not always follow planned routes, and this was known by the management and office staff. Additional staff had not been allocated to ensure all calls went ahead as planned. People's feedback to us was of a service that they could not always rely on. In some cases, people were fine with this, others felt rushed during care calls, not valued and told us it disrupted their daily plans. Overall, the majority of people and relatives were dissatisfied.

Systems of audits had not identified some of the areas for improvement we found at this visit. There were limited audits and actions to show people received their medicines safely and as prescribed. Systems and processes to ensure safe recruitment were not always followed.

Risks for some people were updated and these reflected the support people needed. The provider told us they had spent time since the last inspection, updating people's care plans. However, we checked examples of updated care plans and found these were not always accurate or held conflicting information. Some risk assessments although completed, needed additional information to ensure the overall risks were fully documented. Speaking with staff showed us that despite gaps in records, they knew how to manage those risks.

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

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 26 May 2022). The provider continues to send us monthly action plans as per the imposed conditions on their registration which we imposed on 29 March 2021. At this inspection we found insufficient improvements had been embedded into everyday practice. The provider was now in breach of regulation 12, regulation 17, regulation 18 and regulation 19. The service is now rated inadequate.

Why we inspected
The inspection was prompted in part due to concerns received about people not receiving care at the required time and for the right amount of time. We also received some information that people were not always transferred safely, or that some people did not receive their medicines safely. A decision was made for us to inspect and examine those risks.

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.

This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed to inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for A&K Homecare Services on our website at www.cqc.org.uk.

Follow up

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our well led findings below.

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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 Care Act 2014.

Inspection team
The inspection visit was completed by 3 inspectors. Two inspectors visited the location's office and 1 inspector worked off site, making telephone calls to people and relatives.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses. CQC does not regulate premises used for domiciliary care; this inspection looked at people's personal care and support.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

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

Notice of inspection
This inspection visit was announced. We gave short notice of our visit to ensure staff and management were available.

Inspection activity started on 14 December 2022 and ended on 21 December 2022. We visited the location's office on 14 December 2022.

What we did before inspection
We reviewed the information we held, such as people and relatives' feedback and statutory notifications, as well as any information shared with us by the local authority, commissioners and the local government ombudsman. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 5 people who received a service and 4 relatives to get their experiences about the quality of care received. We spoke with 4 members of care staff, an administrator, a deputy accounts support officer, a finance director and the registered manager.

We reviewed a range of records. This included 5 people's care records and samples of medicine records and associated records of their care. We looked at records that related to the management and quality assurance of the service and risk management. We reviewed 2 staff recruitment files.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

- We could not be confident people always received their prescribed medicines safely. The systems to support safe medicines practices were ineffective.
- Medicine Administration Records (MAR) did not always correlate with people's care plans. It was not always clear what medicines a person had been prescribed, what the dose was, or if staff needed to administer them. For example, MAR records for one person, did not match what the registered manager and staff told us they were prescribed and administered.
- People who required 'as and when' medicines did not have a protocol in place to tell staff, when and how the medicine should be administered, and at what dosage. This information is essential to ensure staff follow a consistent approach and people receive their medicines when needed.
- Some medicines required stricter controls, for example liquid pain relief. The registered manager told us staff should not administer this medicine because they had not been trained to give this type of medication. One person's MAR showed this medicine had been regularly administered by staff, even after the registered manager told us it had been stopped by them.
- We asked the finance director for this person's current MAR to assure ourselves what medicines should have been administered and were being given at the time of the inspection. We were not sent a copy. Instead, we were sent photographs of the person's medicines, some of which were not listed on the MARs we reviewed. This meant we could not be confident this person received their medicines safely.
- Best practice medicines guidance was not followed. For example, MARs did not always show the prescribed dosage and frequency of each medicine a person required. This information is important to ensure the prescriber's instructions are correct and people are protected from receiving incorrect medicines.

Systems had not been established to ensure safe medicines practices were followed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- People were not protected because staff recruitment checks were ineffective.
- The provider had policies to ensure staff were recruited safely and were suitable for their roles by conducting relevant pre-employment checks. However, those checks were not always completed.
- One staff member worked unsupervised with people without appropriate references.
- Two staff had started to work with people before the provider had seen their Disclosure and Barring Service (DBS) check. Disclosure and Barring Service (DBS) checks provide information including details

about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● Where information on a DBS should prompt a provider to consider a risk assessment, this had not been considered. This placed people at unnecessary risk of receiving care from staff not suitable to work with vulnerable adults.

Safe recruitment procedures were not operated effectively which placed people at risk. This was a breach of regulation 19 (Fit and proper people employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Prior to our inspection we received concerns about the timeliness of people's care calls.
● At this visit, we were not confident the provider deployed enough suitably qualified and experienced staff to meet and support people's assessed needs, especially in the mornings.
● We looked at the provider's electronic care call planner. In those calls we looked at, care calls were completed on or around the times people needed. However, 7 of the 9 people and relatives we spoke with, told us most of their calls were completed for shorter than the agreed times or were late.
● People told us how late or shortened care calls directly affected them. One person said, "I feel sometimes I should rush; they are very busy." One relative told us, "The first visit was due on the Monday and we requested a late morning call. At 12.30pm on the first day they still hadn't arrived. No contact. Other morning calls were late."
● One person shared their experiences with us. They told us, "I've had a great deal of bother over the call times. I've complained. They don't come at the right times." Some people and relatives told us they had made alternative arrangements to get the help they needed because they could not rely on this provider. Where people and relatives had shared concerns with the provider, they told us there had been little or no improvement.
● People and relatives told us where their first call of the day was completed later than planned, their following calls were closer together, and in some cases not needed because of the minimal gaps between calls. Where people needed help with personal care or support with meals, this had a negative impact on them. In these examples, family members helped support their relative, such as helping them with personal care and helping them to get dressed and prepare meals.
● There were systems to monitor, plan and allocate care calls to staff. The deputy accounts support officer who planned calls was confident there were enough staff to allocate calls. However, they and some care staff we spoke with told us if morning care calls were running late, the drivers did not always follow the planned timesheets and made decisions themselves about which call to complete next.
● One staff member said, "Drivers would often stray from the runs and go onto someone else's call that was later. On quite a lot of calls, using our phones, we would log into the next call, but we actually went somewhere else." The staff member told us by doing this, the provider's systems would not be aware certain care calls had not been completed. The staff member said, "So we basically said we were somewhere or at someone's call when we weren't."

Systems had not been established to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed to meet people's care and support packages. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The finance director explained the challenges they faced because commissioners, local authority and social workers often agreed call times with the person, without consultation or agreement with the provider. The provider had begun to agree with people a 'time window' where care staff could arrive at a time that was more realistic.

Systems and processes to safeguard people from the risk of abuse
● People felt safe when staff were supporting them in their home.
● Staff received safeguarding training and knew how and what to do, if poor practice became known to them.
● The registered manager understood their responsibilities for reporting potential safeguarding concerns to the local authority. However, we found an incident from July 2022 had not been reported to us. The registered manager told us the safeguarding team had not pursued this. We reminded the registered manager of their legal responsibility to tell us.

Assessing risk, safety monitoring and management
● At our last inspection we found people's risk assessments required further information, so staff knew how to support people safely and minimise risk.
● At this visit, we found risks to people's health and well-being had been identified and assessed. However, some records lacked detail to guide staff on how to mitigate some risks. For example, one person had a mental health condition and there was limited guidance for staff on how this presented itself for the person or how staff should respond. Another person had a catheter, more detail was required to enable staff to identify possible signs of infection.
● In another example, we found conflicting information about how a person required mobilising safely. In all of these examples, we spoke with staff. Despite the lack of guidance, staff were consistent and confident in their responses that showed they knew how to support people safely.

Preventing and controlling infection
● From people's comments, we could not be confident all staff wore Personal Protective Equipment (PPE) correctly and in line with government guidance at the time, related to the COVID-19 pandemic. One relative said, "Carers wanted to come into the home without wearing PPE. I also saw staff wearing the masks under their chin." A relative said staff did not always wear a uniform.
● There were no systems and processes we saw during our visit that showed the provider ensured their staff were complying with government guidance for the use of PPE. The finance director told us they had plentiful PPE stocks.

Learning lessons when things go wrong
● From people's feedback, staff feedback and from other organisations that commission services, we could not be confident lessons were learned to improve day to day practices. The local authority had tried to engage and support the managers at the service but there was limited engagement.
● Monthly action plans submitted to us by the provider did not always show or clearly record, what had worked well and how they had changed their procedures as a result.

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.

- There was no one currently using the service who lacked the capacity to consent to their care or treatment, therefore, applications to deprive a person of their liberty had not been required.

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- At our last inspection we found systems to monitor the quality of the service were not always effective. There was a lack of oversight of people's individual care and support needs and any risks associated with their care and support. We also found systems and processes to ensure care calls were on time and for the required time periods, were not always completed to people's satisfaction.
- Following our December 2020 inspection, we imposed conditions on the provider's registration. This condition required the provider to send us monthly action plans to tell us what they had identified for improvement, how this would be achieved and by when. The condition specified that the provider needed to maintain an accurate, complete and contemporaneous record in respect of each person, including a record of the care and treatment provided to the person. It also required the provider to have effective governance systems in place to ensure they carry out audits on people's care plans and risk assessments, to ensure information was up to date, accurate and measures were put in place to reduce risks.
- At this visit we found a lack of robust systems and processes within the service to continue to monitor and review the quality of service people received, along with a failure to effectively respond to and record improvements. This had led to some people receiving an ineffective service.
- Systems to update and review care plans were not effective. We found care plans needed more personalised information. In some cases, people told us they did not have any care plans at their home. One relative said, "The lady assessor came Wednesday from A&K. They didn't come before the package started. It was approximately about 10 days into the package. There weren't any records in the home to begin with either." One staff member told us one person they had been supporting for a few weeks still did not have a written care plan in place.
- Systems to improve the timeliness of care calls needed better management. We found people's support and how and when people received their care calls, continued to fall short of expectations. Systems for identifying, capturing and managing organisational risks and issues remained.
- Systems and processes to monitor the quality of recording, medicines management and ensuring staff always attended care calls at the right times and to people's satisfaction, needed more effective scrutiny. Audits and checks, if completed, were minimal and limited in detail. Where concerns were found by us, such as medicines management, an audit was last completed September 2022. The issue we identified had not been identified by the registered manager who told us, "I check but I don't write it down." This meant we could not be assured what, if any actions, had been taken to improve the service.
- The provider's systems of recruitment had failed to ensure all checks were consistently completed at the point of recruitment. This placed vulnerable people at risk.

● Systems to seek, listen and respond to people's feedback about the service, failed to identify the concerns we found during this visit. This was identified at previous inspections and people's feedback showed this had not improved. Where calls were short or later than planned, there was limited, or no evidence, to show us how the registered manager responded to staff who chose to defer from planned routes to go to other care calls that were not scheduled next in planned runs.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;
● The majority of people and relatives' feedback was of a service that did not meet their needs and wishes. People and relatives told us they had raised their concerns. In some examples, telephone calls were not returned or for others, they felt their concerns went unheard.
● The registered manager told us if CQC received negative feedback it would be about people's care call times. During our inspection, people and relatives told us they were frustrated and gave us examples of how this had a negative impact on them.
● We received mixed feedback from staff. Some staff said they were happy working for the service, they felt the staff team worked better than previously through recent recruitment. Other staff were less positive. One staff member explained how they felt pressured by other staff to cut calls short, missing calls because some staff chose to do things their own way rather than following prescribed routes and plans.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working with in partnership with others
● During the planning and post inspection activity, we received some negative feedback from other agencies and public bodies. From their evidence, there was limited collaboration or co-operation by the provider with external stakeholders and other services.
● Discussions and evidence of the actions those organisations had taken to engage with the provider, showed a provider who was not always working with others for the benefit of those people who received a service.

The provider had failed to put in place robust and effective systems to monitor the service, identify areas for improvement and take action to protect people. 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
● The registered manager submitted to us monthly action plans as per conditions on their registration to show us how they were monitoring their service.
● The provider had met the legal requirements to display the services latest CQC ratings on their website.
● The registered manager and provider responded positively to our visit and took steps to address the issues we raised at the time of our visit.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not adequately assess and protect people when staff administered people's medicines. Systems and processes to check people received their medicines safely were not always effective.

The enforcement action we took:

Issues a notice of proposal to cancel provider and registered manager.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured robust quality systems or processes were fully effective to monitor the service appropriately, including people's safety.

The enforcement action we took:

NOP to cancel provider and registered manager registration

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not operate and follow safe recruitment processes to ensure staff were of suitable character to support people safely.

The enforcement action we took:

NOP to cancel provider and registered manager registration

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not always ensure all aspects of people's care and support needs were provided by enough sufficiently trained and qualified staff.

The enforcement action we took:

NOP to cancel provider and registered manager registration