AQT London Limited

AQT Home Care Services

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 16 and 20 June 2016 and was announced. The provider was given 24 hours' notice as we needed to be sure the manager would be available to talk to us. The service was last inspected in August 2014 when it was found to be compliant with the outcomes inspected.

AQT Home Care Services is a domiciliary care service providing personal care to people in their own homes. At the time of our inspection they were providing support to 22 people.

The service had a manager in place. However, they were not registered with the Care Quality Commission. The manager had started the application process to become registered. 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 told us they felt safe using the service, and care workers were knowledgeable about their responsibilities to safeguard people from harm. However, the processes for escalating concerns were not operating effectively to ensure that concerns and allegations were investigated appropriately.

People were at risk of harm and poor support because care plans and risk assessments did not contain the information staff required to provide good quality safe care. Care workers relied on feedback from people, their relatives and more experienced colleagues to know what support to provide. Care plans were not kept up to date when people's needs changed.

The service did not always have enough staff to ensure that people's needs were met. We have made a recommendation about staffing levels.

People and their relatives told us they were supported to take their medicines as prescribed. However, records were not well maintained. We have made a recommendation about recording medicines administration.

People and their relatives told us they thought that staff were good at their jobs. Staff told us they received regular training, although this was not always reflected in the records of training received. Staff did not

receive regular supervision. We have made a recommendation about supporting staff.

The service provided support to people at the end of their lives. End of life care plans did not contain the information required to ensure that people were supported at the end of their lives to have a dignified and pain free death. We have made a recommendation about end of life care.

The systems for monitoring the quality of the service were not operating effectively. Management audits of care plans and records of care delivered had not identified that more information was required to ensure high quality care was delivered.

Where the service was responsible for supporting people with eating and drinking this was recorded in the care plan. People were supported to eat and drink enough and to maintain a balanced diet. The service supported people to access healthcare services as appropriate, but did not update care plans to reflect current advice from health professionals.

The service sought consent from people and their legal representatives in line with legislation and guidance.

People and their relatives told us they thought the staff had a caring attitude. Regular care workers had developed positive relationships with the people they supported. People told us they felt they were treated with dignity and that care staff were respectful to them.

People and their relatives knew how to make complaints and records showed these were responded to in line with the provider's complaints policy. People and their relatives told us the service responded well to any concerns they raised and made changes as requested. The provider completed annual surveys of staff and people who used the service to obtain feedback about the service.

We found five breaches of the Regulations. You can see what action we have asked the provider to take at the end of the full version 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?

Inadequate

The service was not safe.

People were not protected from avoidable harm and abuse as the processes in place to escalate concerns were not operating effectively.

Risk assessments were not robust and did not include details of how risks were managed.

People's medicines were not always managed so they received them in a safe way.

Staff were recruited in a way that ensured they were suitable to work in a care environment. However, there were not always enough staff available to ensure people received care.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff training records were not up to date, and staff were not receiving supervision to ensure they had the knowledge and skills they needed to carry out their roles.

Consent to care was sought in line with legislation and guidance.

People were supported to eat and drink enough and to maintain a balanced diet.

People were supported to access healthcare services when needed. However, updated advice from healthcare professionals was not incorporated into care plans.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The care plans for people being supported at the end of their lives did not contain sufficient information to ensure they would have the death they wanted.

People told us they thought staff cared about them.

Staff had developed positive, caring relationships with people using the service.

People and relatives told us they felt they were respected by care staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans lacked details and were not always personalised.

People and relatives knew how to complain, and complaints were responded to in line with the provider's policy.

People and relatives told us they felt the service responded to their concerns.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People and their relatives said the service was not consistently well managed, though this was improving.

There were no effective mechanisms to monitor and improve the quality of the service.

Staff told us they did not feel supported by the provider.

AQT Home Care Services

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.

The inspection took place on 16 and 20 June 2016. The provider was given 24 hours notice of the inspection as we needed to be sure the manager would be available to talk to us.

The inspection was conducted by one inspector.

Before the inspection feedback was requested from local authority commissioning teams and the local Healthwatch. Before the inspection, the provider 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. We reviewed the information we already held about the service, including statutory notifications we had received and previous inspection reports.

During the inspection we spoke with three people who used the service and six relatives. We spoke with ten members of staff including the proprietor, the manager, a coordinator, an administrator and six care workers. We viewed four staff files including recruitment, supervision and training records. We viewed the care files of four people who used the service including support plans, risk assessments, medicines records, needs assessments and records of care delivered. We also reviewed various records, documents and policies relevant to the running of the service.

Inadequate

Our findings

People told us they felt safe with their care staff. One person said, "I feel I can trust them." Most relatives told us they felt people were safe with their care staff. One relative said, "I'm confident the carers know what they are doing and [my relative] is definitely safe." However, one relative told us they did not have the same confidence in the staff. They said, "More times than not I wouldn't feel safe to leave the house when the carers are there, particularly when they aren't familiar with [my relative]."

Staff were knowledgeable about how to protect people from avoidable harm and abuse. They knew to record and report any concerns they had. One staff member said, "We put it [allegation of abuse] in the report and tell the manager or the on-call." This was despite the fact that records showed that only two care workers had received safeguarding training since 2014. After the inspection the provider sent us a record that eight care workers had attended safeguarding training in July 2015 and a further seven staff attended safeguarding training after the inspection.

The service had a policy regarding safeguarding adults from harm, however, this did not include the contact details of the local safeguarding authorities for concerns to be escalated. In addition, the policy did not clarify that the investigation of allegations is the responsibility of the local safeguarding authorities. Incident records were reviewed, which revealed one incident that should have been raised as a safeguarding alert with the local authority. When this was discussed with the manager they did not know the process to raise the alert. During this discussion, the manager was asked how they would respond to an allegation of mistreatment by one of their care staff, their response recognised the service had faced a similar situation. However, they did not include raising a safeguarding alert with the local authority and they had not considered it as a safeguarding matter. This meant that people were not protected from avoidable harm and abuse as the service did not have proper procedures in place to ensure safeguarding processes were followed.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans contained a range of risk assessments relating to different areas of support including, personal hygiene, continence, dressing, medicines, behaviour, wandering, eating and drinking, moving and handling, mobility and skin integrity. Files also contained environmental and equipment risk assessments. These contained limited information for carers to follow to ensure they knew how to mitigate risks people faced. For example, one person required the use of a hoist for all transfers. The assessment stated, "[Person] is

immobile. They require full transfer assistance from arm chair / wheelchair into and out of bed." The description of the assistance in the plan stated, "Client is hoisted." This did not give care staff clear instructions on how to mitigate the risks. The manager told us that staff received training in moving and handling and this ensured the risks were managed appropriately. The provision of training to staff is not a replacement for a personalised risk assessment.

The provider had a contract to provide end of life care to people. These people had complex health needs and faced multiple risks during the provision of care. For example, tube feeding and the use of specialised health equipment to manage their symptoms. The risk assessments for one of these people were insufficient on the first day of our inspection as they did not detail the measures in place to mitigate risk. On the second day, updated risk assessments were provided. Although these had more detail, they remained insufficient. For example, this person was at risk of pressure wounds but the instructions for carers were vague and did not provide the level of detail required to minimise risk. It stated, "[Person] needs to be repositioned on every visit. Monitor and report any changes." Later in the document carers were instructed, "The prescribed barrier cream to be applied after washing and person care." There were no details about the nature of changes carers should be aware of, or details of how or where to apply the prescribed cream. This information was also not included on the medicines administration records. The manager said they did not provide that level of detail in risk assessments as, "We rely on the training." The manager also informed us this person had breathing difficulties but this was not recorded in their risk assessment. This meant there was a risk that this person did not receive safe care.

The above is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a robust recruitment policy which detailed the processes for safe recruitment. Records showed that staff completed an application form and interviews were recorded. Applicants provided two references which were checked by the service and proof of identity. The service's policy stated they would conduct criminal records checks to ensure that staff were not unfit to work with adults at risk. Records showed that although applications to the Disclosure and Barring Service had been submitted, some staff had not yet received their results. The service had not taken any measures to mitigate against the risks that these staff were unfit to work and they were lone working with people in their homes. This was brought to the attention of the manager who immediately implemented measures to ensure the risks were managed.

The manager told us the recruitment of carers was "a challenge" and they did not think they had enough staff. This was supported by four of the care workers who did not feel the service had enough staff to provide care in a safe way. Staff told us they were often contacted to cover work, or supplied with rotas which contained work at times they had told the service they were unavailable. People and their relatives told us that they were aware the service sometimes struggled to provide staff when their regular carers were not available. One relative told us, "In the last two weeks [my relative] has had four different carers and two no shows. On Saturday they told me they couldn't cover it and on Monday they couldn't get someone here in time so I cancelled it." Another relative told us, "We have had spells where there were issues with staffing." Most people and relatives we spoke with told us staffing issues had improved. The manager told us a recent recruitment drive had resulted in only two staff joining the service.

We recommend the service seeks and follows best practice guidance on staffing levels and recruitment practice for domiciliary care services.

The service supported people to take prescribed medicines. Care plans contained a detailed list of the medicine, dosage, how it should be administered and where it was stored. However, this list did not match

the medication administration records used in the person's home. One person had their medicines crushed as they had difficulty swallowing. Although there was a record of correspondence with the GP confirming this, there were no instructions for carers regarding how to crush medicines safely. This was discussed with the manager who sent us copies of instructions for carers after the inspection.

The medicines administration record (MAR) was completed by care workers, who copied the information from the prescription labels. This was the only instruction information available for care staff. When medicine was prescribed on a 'take as needed' basis there were no instructions for staff about when to offer the medicine or when it might be needed. The MAR record had gaps where care staff had not signed to indicate whether a medicine had been administered or not. The person's relative told us they had no concerns about medicines administration, they said, "I know that [relative] always gets them. I'm confident they are doing it." However, this was not supported by the records.

We recommend the service seeks and follows best practice guidance on recording medicines administration.

Requires Improvement

Our findings

The service had a policy regarding staff support and supervision. This stated that staff should receive a support session once every three months. Staff told us they did not receive regular supervision. One member of staff said, "I have only had it [supervision] once or twice, a very long time ago." Another member of staff said, "It [supervision] used to happen, we had spot checks to make sure things were ok. It's not happened for a while." Staff files showed that no supervisions had been recorded since December 2015. Records showed that staff had been called in for individual meetings to discuss performance issues, but these did not consider the personal development of the worker. The manager told us they completed an annual appraisal rather than supervisions and they planned to introduce spot checks. After the inspection the provider sent us two appraisal records, the most recent of which was completed in June 2015. They also sent us one spot check that had been completed in March 2016 but was not signed by the worker.

This is 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.

Records showed that where people had capacity they consented to their care by signing their care plans. Where people lacked capacity, records indicated that relatives who had the legal authority to do so made decisions. Staff told us the people they worked with were able to consent to their care on a daily basis, and they checked this as they provided support. People and their relatives told us that their care staff would always ask before performing care tasks. One relative said, "They are respectful to [my relative]. They do it [provide support] in a way [relative] likes." The service was seeking consent in line with legislation and guidance.

Most people were supported by family members to access health care services. Where people had significant health needs, this was recorded in their care plans. If people became unwell while receiving support, care staff were confident to contact the office for additional support to ensure people's health needs were met. One relative described how the service had liaised with various different community health professionals to ensure healthcare support for their relative. They said, "They always go the extra mile to

make sure she has the help she needs. They are very flexible, including working with community health services."

Where the service was responsible for ensuring that healthcare advice was followed this was not reflected in their care plans. The manager was asked how care workers were informed of changes to people's healthcare needs. They said, "We inform the regular carers by phone or by text message. We don't update the care plan." This meant there was a risk that the most up to date health advice was not available for all staff working with people. The manager told us they would update care plans to reflect the most recent healthcare advice.

Where the service was responsible for supporting people with preparing and eating their meals this was described in their care plans. The assessment noted if people required a specialist diet for health or religious reasons. One person's plan stated, "[Person] is able to drink herself, but may require support if she is feeling weak and tired. [Person] should be encouraged to eat herself, but will require support if she is tired or weak." There were no details of this person's preferences or descriptions of the actual support required. This was discussed with the manager who advised they would update the plan with more detail, the person's family provided most of their food.

People and their relatives told us they thought staff were good at their jobs. One person said, "They know what they are doing." A relative said, "I'm confident they are good at their jobs." Staff told us and records confirmed they received training in moving and handing, medicines, infection control, nutrition, health and safety, dementia awareness, person centred care and inclusion and equality. The manager and staff described training that had taken place within the last six months, including moving and handling and medicines training which were not included in the records. This meant the training records had not been kept up to date.

Requires Improvement

Our findings

People and their relatives told us care staff treated them in a caring manner. A relative told us, "I feel they [care staff] care deeply about [my relative]." One person said of their care worker, "She likes to make people happy, she's very thoughtful and very nice." People and their relatives told us they thought that the care workers knew them well and communicated with them in a respectful and kind manner. One relative said, "They know [my relative] really well. They can pick up on body language and respond really well." Another relative said, "They seem to really like [my relative], it's not just doing a job."

Staff told us they built up relationships with the people they supported by talking to them and their relatives. One care worker described how they now understood one person's communication, they said, "They can't speak now, but use their eyes and shoulders. [Person] will make a little sound, and blink twice for yes." Another care workers said, "When I'm giving care, I still chat and check it's all OK as I go."

People told us they received care in a way they liked and that was in accordance with their wishes. One person said, "They are very good, I like them, they do deliver quality well." Relatives were involved in making decisions about people's care where this was appropriate. Relatives told us they were involved in people's needs assessments and felt that they were listened to. One relative said, "All the family are very involved and we [the service and the family] all exchange information."

Care staff told us how they ensured that people were offered choices on a daily basis. One care worker described how the person they supported chose all the activities they did. They said, "[Person] is very clear about what [they] want. [They] tell me what to do and we go ahead and do it." Relatives said they were offered a choice of care workers. Preferences regarding the gender of care workers were recorded in care plans.

People and their relatives told us that care workers treated them with dignity during care tasks. One relative described how care workers waited outside the bathroom until their relative called them in using a bell. Another relative described how their relative felt respected as they had a consistent care worker. They said, "[Person] does not cope well with new people, they like to develop relationships with the carers. We insisted on a regular person who comes seven days a week. This works well."

Records showed that people and their relatives had contacted the service to clarify and amend what care should be provided during visits. The correspondence showed that the service had agreed to these changes. However, the care plans had not always been updated to reflect the changes. This had led to some care

workers not knowing that care plans had changed and feeling that they were being asked to do tasks outside of their remit. This was discussed with the manager who said he would ensure all care staff were made aware of updates to care plans.

The service had a contract to provide end of life services to people in their homes. The nature of this service meant that packages of care had to be put in place very quickly. The end of life care plans reviewed showed that care was being delivered jointly with people's families. The manager told us that in order that people could return home as quickly as possible a shortened assessment and care plan were used. These lacked detail and care workers had to rely on the person and their family members to know how the person wished to receive their care. The plan was updated during the inspection to include more detail, however, there was no information about pain management or what to do in the event that the person's condition deteriorated. This meant there was a risk people were not being supported at the end of their lives to have the death they wished for.

We recommend the service seeks and follows best practice guidance about care planning for people at the end of their lives.

Requires Improvement

Our findings

Feedback from people and their relatives was mixed regarding how involved they felt in needs assessments and care planning. Some people and relatives felt they had been fully involved in the process. One relative said, "They keep us in the loop, we have reviews regularly." However, other people and relatives said they had not been involved. One relative said, "We were promised a review that's not happened. It would be useful to iron out issues."

Care plans were inconsistent regarding the levels of personalisation. Some contained information about people's lives before they received services, with details about their preferences for care. For example, one plan provided details of what activities the person enjoyed and stated that regarding food, "[Person] has always been very adventurous in trying new foods and is happy to do so now." Other plans were task focussed and contained limited information about people's preferences for care. For example, one person's agreed daily plan stated, "Personal care assistance, change bed sheets as needed, hoover bedroom and breakfast."

The manager, staff, people and relatives all confirmed that the details regarding people's preferences for how care was delivered were confirmed through conversations with people, their relatives and more experienced care workers. One relative said, "I have to talk them [care workers] through every time. When a new carer comes it's on me to tell them what to do." A second relative said, "When a new carer comes the regular carer will explain and sometimes I'll chip in. No one ever looks at the care plan, the more experienced ones teach the others." This meant there was a risk that people did not receive care according to their preferences as the service was relying on informal handover of information. Personalised information about people's needs and how to deliver care was not clearly recorded.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a complaints policy with clear timescales for responses by the provider. After the inspection the provider amended the policy so that it included the correct details of how to escalate complaints. Records of complaints made showed these had been responded to and resolved in line with the provider's policy. However, there was no audit or thematic analysis of complaints. This meant the opportunity to ensure that lessons were learnt and mistakes were not repeated was missed.

People and their relatives were sent feedback questionnaires each year. The most recently of these had

been completed in December 2015. The results showed that people and their relatives strongly agreed that "Staff show kindness and understanding." The response to the statement, "If the agency needs to change the care worker they will consult me first." was more mixed, with fewer people saying they strongly agreed with the question. There was no action plan associated with the survey to show the service had responded to this feedback.

People and their relatives told us they found they could raise concerns easily and the service would respond. One relative told us, "We had some problems with one of the workers, and had a period where carers weren't coming. We made a fuss and it's sorted now." Another relative said, "They're always very good at getting any issues resolved. They responded really well to me." One person told us they had raised concerns about one of their care workers, they said, "We had some that we didn't find up to standard so we said and now we have different ones."

Requires Improvement

Our findings

The service had recently had a change of management. The current manager was not yet registered with CQC at the time of our inspection but told us they had started the process of registration prior to our inspection. People and relatives told us there had been some issues around the coordination of care workers when the change in management took place in March 2016. One relative said, "We did have a period of people not coming, but they responded well. [Manager] put it right." Another relative said, "I noticed the change when the old manager left, things were less organised." A third relative commented, "They [the service] can be a bit disorganised, like for planning of shifts when staff are on holiday. It's not that we worry that [relative] won't be looked after, but arrangements might be different." Several other people told us there had been issues with the rota, where two care workers had turned up for the same visit, or no workers had come at all. These issues had been resolved for most people.

Three members of staff told us they frequently received rotas that did not reflect their availability, despite them having informed the service of when they were available to work. This had the largest impact on staff who worked with multiple people. Staff who only worked with one or two regular people told us they had no problems with the rota.

The service did not hold staff meetings. They had been attempted in the past but due to low attendance were not currently being scheduled. Staff told us they would find it helpful to have these meetings as they thought it would help improve communication in the service. One member of staff said, "Staff meetings would be helpful."

Four of the staff we spoke with told us they did not find the service supportive. They told us they did not feel that they were listened to if they raised problems or concerns. One member of staff said, "They [manager] isn't listening to us." Another member of staff said, "I think [manager] can't handle problems. It feels like he is having a go at us when we raise problems." A third member of staff raised concerns that the office based staff had a high turnover rate. They said, "The office staff change every five months. That tells me something is very wrong." Other staff told us that there had been issues at first, but these had now been resolved. Two of the relatives we spoke with were aware that some staff did not feel supported by the organisation.

The manager recognised that there were areas where their knowledge needed to improve, specifically with regard to safeguarding processes, risk assessments and the Mental Capacity Act 2005. The manager told us, and records confirmed, they had received no formal training since joining the organisation. They had started a level five qualification but this was not recorded in the training records.

The manager told us that records of care and medicines administration were checked on a monthly basis before being uploaded to a computerised system for secure storage. This was how the quality of the service provided was checked. However, there were no records to support that these checks had taken place. In addition, the recently uploaded medicines administration records had not been fully completed but this had not been identified as an issue by the service. The existing audit and quality assurance mechanisms had failed to identify the issues identified with the quality of care plans and risk assessments found during this inspection.

The service collected information about the service through the use of questionnaires and for contract monitoring purposes. The information collected for contract monitoring purposes related to specific health outcomes for people who were funded under this contract, it was not an evaluation of quality. There was no plan for developing the service or responding to themes within the feedback. This meant that the service was not able to demonstrate that it was monitoring the quality of the service or had a plan for improving the quality of the service.

The above is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 9 HSCA RA Regulations 2014 Person-centred care Plans of care were not person centred and did not contain the detail required to ensure people's assessed needs were met. Regulation 9(1)(3)(b)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments lacked detail and did not contain the information required to ensure people received safe care and treatment. Regulation 12(1)(2)(a)(b)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were not established or operated effectively to ensure people were safeguarded from avoidable harm and abuse. Regulation 13(3)

Regulated activity	Regulation

Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The quality assurance and audit processes in place were ineffective and did not identify or address issues with care plans and risk assessments. Regulation 17 (1)(2)(a)(b)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not receiving the support and supervision they needed to develop in their roles. Regulation 18(2)(a)