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

Summary of findings

Overall summary

About the service
A&K Home Care Services Ltd is a community-based care provider that provides personal care to people living in their own homes. At the time of inspection there were 34 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
The service has not been able to achieve a good rating since our inspection in 2017. Good care is the minimum standard of care that people receiving services should expect and deserve to receive. Since this time, the service has been inspected 5 times where it has been rated either requires improvement or inadequate. On 4 of these inspections, the provider has been in breach of the regulations, with some regulations being continually breached.

At this inspection we continued to find a lack of robust systems and processes in place to continually monitor and review the quality of care and support people received.

The registered manager and staff responsible for completing audits and checks, had limited records to show us what they had checked, what they had found, and what they had done to improve the service. Where checks had been completed, such as medicines audits, they had not identified some of the shortfalls found during our inspection.

Some people and relatives continued to raise concerns to us about the timeliness of their care calls. There were not enough suitably trained staff to ensure people received a consistently reliable service which met their individual care and support needs. Care call times continued to be significantly shorter than they should have been, with limited or no overview by the registered manager.

Staff received training to support them to undertake their role. However, this training did not always ensure staff provided safe, effective care and support. For example, some staff had not received sufficient moving and handling training.

Staff were recruited safely. Pre-employment checks were now completed in line with the providers expectations.

Overall, people received their prescribed medicines. Medicine Administration Records (MAR) showed staff had administered medication in line with people's individual prescriptions. However, medication checks had not always identified poor medicines practices.

People felt protected from the risk of abuse and overall, felt confident in the staff who supported them in

their home. Most people did not require support with eating and drinking. Where this was a need, information was provided in care plans.

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.

The registered manager told us they worked with other healthcare professionals to ensure people had access to healthcare services. Staff told us they would not hesitate in contacting a doctor if a person was unwell.

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 inadequate (published 10 February 2023). Breaches of the regulations were found. The provider continues to send us monthly action plans as per the imposed conditions on their registration which were imposed on 29 March 2021.

At this inspection we found insufficient improvements had been embedded into everyday practice. We found the provider remained in breach of the regulations.

Why we inspected
We carried out an announced focused inspection of this service on 14 December 2022. Breaches of legal requirements were found and following this visit, we took enforcement action.

We undertook this announced focused inspection to check the provider had improved sufficiently and the systems they told us they had improved, now met the legal requirements. This report only covers our findings in relation to the Key Questions safe, effective 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 remained the same based on the findings from this inspection. Please see the safe, effective and well led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We have identified continued breaches in relation to Regulation 17 (Good governance) and Regulation 18 (Staffing).

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service remains 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 next inspect, 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? The service was not safe. Details are in our safe findings below	**Inadequate**
Is the service effective? The service was not always effective Details are in our effective findings below	**Requires Improvement**
Is the service well-led? The service was not well-led Details are in our well led findings below	**Inadequate**

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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 Health and Social Care Act 2008.

Inspection team
The inspection was completed by 2 inspectors and an Expert by Experience. Two inspectors visited the location's office, and the Expert by Experience made telephone calls to people and relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes.

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

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

Notice of inspection
This inspection was announced. We gave 24 hours' notice of our visit. This was so the provider would be available to support this inspection and to tell us about the improvements they had made, since our last

visit.

Inspection activity started on 03 May 2023 and ended on 10 May 2023. We visited the location's office on 03 May 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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 2 people and 6 relatives about their experience of care provided. We spoke with 4 members of care staff, a field care supervisor, 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, 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 4 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 our last inspection we rated this key question inadequate. At this inspection the rating has remained inadequate. This meant people were not safe and were at risk of avoidable harm

Staffing and recruitment

At our last inspection, 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.

At this inspection, not enough improvement had been made and the provider remained in breach of regulation 18.

- Conversations with people, relatives, staff and the provider's own systems, showed there were not enough staff to ensure people received a consistently reliable service which met their individual care and support needs.
- At our last inspection, we found care call times were often late or significantly shorter than they should have been. At this inspection, the provider's electronic planning system continued to show late calls or calls that were not for the agreed duration. The system recorded 749 care calls were completed in less than the agreed time duration. For example, 2 people required 30-minute care calls, which were regularly shorter than agreed. Some calls were less than 5 minutes in duration without an appropriate rationale. The provider assured us staff always recorded a reason; however, records did not always evidence this.
- Some people and relatives continued to raise concerns about the timeliness of their care calls. Comments included, "We never know when they [staff] are going to get here. It can be 17 or 18 hours at night-time [between visits] and we have never been called to say why they are late. They will stick to the times for a couple of weeks and then it went all to pot." Also, "They [staff] did not stay the thirty minutes when I [Relative] have been there. Probably 10-15 minutes. [Person] missed her medication this morning because the staff came this afternoon."
- Some staff were not suitably skilled and trained to carry out their role safely. For example, some staff told us they had not received sufficient moving and handling training. Experienced care staff would show newer staff members how to use the equipment without being appropriately trained as trainers. One staff member told us, "I have had new staff shadow me and I have to show them how to use the hoist. But I don't know if I am doing it right."
- Another staff member told us how they had observed poor manual handling practices and explained, "My one concern was how staff moved people on double up calls. There were instances where staff pushed people's knees when they should have used the hook on the back of the sling to aid the person into the chair."
- People and relatives did not always have confidence in staff having the right skills to support people

safely. One relative told us, "90 percent of the time they would be asking how to use the hoist."

This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, 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.

At this inspection, enough improvement had been made and the provider was no longer in breach of regulation 19. However, further improvements were needed.

● Staff were recruited safely. Pre-employment checks were now completed in line with the providers expectations. For example, satisfactory Disclosure and Barring Service (DBS) checks were received before staff could work alone with people. 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.
● References had been sought before staff commenced employment, however it was not always clear if these references had been verified.

Using medicines safely

At our last inspection, 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.

At this inspection, enough improvement had been made and the provider was no longer in breach of regulation 12. However, further improvements were needed.

● Overall, people received their prescribed medicines. Medicine Administration Records (MAR) showed staff had administered medicines in line with people's individual prescriptions.
● Electronic MARs had been implemented so more robust checks could be made to ensure medicines were given safely. However, these checks had not always identified where a person's MAR had not recorded each medicine to be administered. For example, the MAR recorded that 'blister pack' had been administered, but not what medicines were contained within the blister pack. Information on CQC's website for providers stated there must be an accurate record of the individual medicines contained in the blister pack. This should be dated and kept with the medicines administration record. It was not. We discussed this with the provider who told us they felt this risk was mitigated as the information was contained in the care records.
● Most people who required 'as and when' medicines to treat short-term conditions like pain had a protocol in place to tell staff, when, how and what dose, these medicines should be given safely. However, we found one person's 'as and when' medicines were missing from their MAR. This meant staff could not record on a MAR if these had been administered during the 3 weeks prior to our inspection. This affected the same person we identified as not having an 'as and when' protocol in place at our December 2022 inspection.

Assessing risk, safety monitoring and management
● At our last inspection we found people's risk assessments required further information to enable staff to know how to support people safely.
● Since our last inspection, the provider had focused on making improvements to care records. Whilst we

recognised some improvements had been made to some records, we found inconsistencies in how risks to people's health and well-being had been identified and assessed. For example, one person had a change in their care needs mid-April 2023; however, their records and risk assessments had not been updated to reflect this change.

Preventing and controlling infection

● At our last inspection, there was limited assurance about safe infection control processes and people told us staff did not always wear appropriate uniform of personal protective equipment (PPE). At this inspection, improvements had been made.

● Staff told us they wore PPE appropriate to the care task and could explain the importance of good hand hygiene. This was confirmed by people and relatives who told us overall, good infection control processes were followed.

Learning lessons when things go wrong

● Since December 2020, the provider submitted monthly action plans to us to show us how they planned to continually improve the service. A succession of inspection ratings less than good overall, demonstrated lessons had not been learnt to improve outcomes for people. There was limited evidence to always show or clearly record, what had worked well and how they had changed their procedures as a result.

● Since our last Inspection in December 2022, we could see some improvements, however, there continued to be a lack of proactive measures to show what had been learnt and how that translated into everyday improved practices.

Systems and processes to safeguard people from the risk of abuse

● People felt protected from the risk of abuse and overall, felt confident in the staff who supported them in their home. One relative commented, "They did everything thoroughly and treated [person] with dignity."

● Staff received safeguarding training and knew what action to take to protect people. One staff member told us, "Safeguarding is making sure people are well looked after. I've got no concerns about how people are treated, but I would report anything I was concerned about."

● The registered manager understood their responsibilities for reporting potential safeguarding concerns to the local authority.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection where we assessed effective, we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff received training to support them to undertake their role. However, this training did not always ensure staff provided effective care and support. For example, manual handling training was delivered via eLearning (online resource). New staff received an induction which included observing experienced members of staff who themselves, had not been trained to deliver this training to others in line with good practice guidelines.
- Staff told us they felt the training could be improved. One staff member told us, "The company needs proper training. There is a lack of physical face to face training. With eLearning, some staff just go straight to the quiz at the end and answer tick box questions. It is my first time in care. Everything I learn is actually being on the job rather than the training."
- Although staff felt confident to raise concerns with management, not all staff had received a recent supervision to discuss their professional development

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

- People's needs and preferences had been assessed by the provider or the local authority before they received support from the service.
- Following the concerns identified at our last inspection in December 2022, the provider was in the process of reviewing people's care plans to ensure these reflected their current needs and preferences. This was described as a 'work in progress' at the time of our inspection and 14 people's care plans still needed to be reviewed. This meant staff did not always have accurate and up to date information to ensure people received effective care and support.
- Where care plans had been reviewed, further detail continued to be required to ensure people received effective care. For example, 1 person's catheter care plan did not contain details of how to identify possible signs of infection.

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

- At time of our inspection, most people did not require support with eating and drinking. Where this was a need, information was provided in care plans.
- Staff knew people's nutritional needs and always ensured people were left with access to food and fluids. Staff knew to report any concerns with people's eating or drinking to people's families and the management team.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live

healthier lives, access healthcare services and support
● The registered manager told us they worked with other healthcare professionals to ensure people had access to healthcare services.
● Staff told us they would not hesitate in contacting a doctor if a person was unwell. There had only been one accident since our last inspection and records showed emergency help had been sought in a timely way.

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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.
● At the time of our inspection, people supported by the service had the capacity to consent to their care.
● The provider worked within the principles of the MCA and encouraged people to make their own choices. One staff member told us, "We don't make decisions for people. They tell us what to do and we do the things they like."

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 our last inspection we rated this key question inadequate. At this inspection the rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection, 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.

Not enough improvement had been made and the provider remained in breach of regulation 17.

● The service has not been able to achieve a good rating since our inspection 2017. Good care is the minimum standard of care that people receiving services should expect and deserve to receive. Since this time, the service has been inspected 5 times where it has been rated either requires improvement or inadequate. On 4 of these inspections, the provider has been in breach of the regulations.
● At this inspection we continued to find a lack of robust systems and processes in place to continually monitor and review the quality of care and support people received.
● The registered manager and staff responsible for completing audits and checks, had limited records to show what they had checked, what they had found, and what they had done to improve the service.
● Where checks had been completed, such as medicines audits, they had not identified some of the shortfalls found during our inspection, including the insufficient detail on MARs. The service supported 6 people with their medicines, yet their own audit did not check all 6 people received medicines safely, only a percentage.
● We repeatedly asked the registered manager for examples of quality checks they completed to ensure they provided safe and effective care. The director from the provider company assured us the registered manager would have completed checks and these would be sent to us following our visit. During our visit, we were only presented with one audit, despite numerous requests to see what they told us they had implemented. Following our visit, we were not sent any further audits or checks.
● Systems to improve the timeliness of care calls continued to be ineffective. The provider ran a report to check people received their care calls on time and for the right duration. However, this report was not audited to identify patterns and trends or to act on any shortfalls. The report for April 2023 showed 27.1% of care calls were not delivered in line with the agreed time duration. There was no evidence of what action had been taken as a result of these findings.

The continued failings to learn, improve and drive improvements through robust and effective quality

assurance and scrutiny meant this was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People and their relatives provided mixed feedback about the management of the service. Some commented they would recommend the services whilst others would not. One relative told us, "Yes, definitely. The carers seemed happy, everything was fine" whilst another person said, "No. Because of call times and communication. It never improved consistently."

● Overall, staff felt the service was managed well and told us the registered manager was approachable. One staff member commented, "Both [registered manager] and [finance director] were nice to me. They were fair. We would go to the office and they were there. They were approachable."

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

● There had been no incidents since our last inspection where the provider had been required to follow the duty of candour process. However, the registered manager understood their responsibilities under duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Surveys had been sent to people and their relatives to gather their feedback about the care and support provided. Records showed some were happy with the service, while others were not.

● We received mixed views from people and relatives about how well the service engaged with them. One person told us, "They had regular surveys, but nothing ever got changed and communication never improved" while others felt communication was good.

● One person had expressed they were unhappy their morning care was getting too late. The provider had responded to this feedback and records showed this person was now receiving the care call at their preferred time.

Working in partnership with others

● At the time of our inspection, the local authority had decided to de-commission with the service. This meant new providers would be taking over some peoples care calls. Those people and their relatives had been informed.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 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:

Previous Notice of Proposal to cancel provider and registered manager registration remains

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:

Previous Notice of Proposal to cancel provider and registered manager registration remains