

Angels Care at Home Limited

Angels Care At Home Ltd

Inspection report

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20 January 2020
23 January 2020

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service:

Angels Care at Home Limited, referred to as Angels Care at Home in this report, is a domiciliary care agency registered to provide personal care to people living in their own homes. The service operates in Swindon and surrounding areas. On the day of the inspection 29 people were supported by the service. Not everyone who used the service 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:

People said they were safe. The provider ensured staff were safely recruited. Where people needed help with taking medicines they were supported to do so. People's care plans contained risk assessments where people were found to be at risk. However, we found when people's needs changed the records had not always been promptly updated. Staff adhered to infection control good practice and had access to protective personal equipment.

People told us they were supported to have choice and control of their lives and staff respected their rights to make own decisions. However, we found the records surrounding capacity assessments were not in line with the Mental Capacity Act Code of Practice.

People's needs were assessed prior to commencement of the service to ensure these can be met. People had the help where needed to meet their nutritional needs and people's care plan described the help people required around their meals in details. Staff received ongoing training and told us they were well supported.

People said staff remained caring and people's dignity and privacy was respected. People's care records showed people were involved in care and their independence was promoted.

People's care plans were detailed and included people's life history, hobbies and communication needs. People knew how to raise concerns and said when they complained their concerns had been addressed.

The provider's systems to monitor the quality of the service were not fully effective and the provider was in a process of implementing a number of improvements as outlined in their action plan. The registered manager failed to meet some of their regulatory requirements, such as submitting notifications. The management were open and honest, staff said the culture at the service improved. The team worked with external partners as needed.

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 (report published 18 January 2019). There was a breach of regulation identified around the records and quality assurance. We issued a requirement notice and asked the provider for an action plan. The provider sent their action plan to us in which they stated actions they implemented to achieve compliance. We also made a recommendation surrounding documentation that related to Mental Capacity Act.

At this inspection we found some improvements had been made, people's care plans were being updated and the provider was in a process of implementing a new electronic system for the care planning. We however found the quality assurance systems were not always in place or fully effective. You can see what action we have asked the provider to take at the end of this full report. We also found concerns around people's care plan surrounding consent and that the provider did not always notify us about reportable incidents.

Why we inspected:

This was our scheduled, planned inspection based on previous rating.

Enforcement

At this inspection we identified breaches in relation to consent, the fact the provider did not always notify us about reportable incidents and there was a lack of effective systems to monitor the quality of service. During this inspection we identified breaches of regulations 11 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a breach of regulation 18 of Care Quality Commission (Registration) Regulations 2009.

Follow up:

We agreed with the provider they will submit to us monthly updates with the progress made. We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

More information is in detailed findings below.

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 always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement ●

Is the service caring?

The service was caring.

Details are in our caring findings below.

Good ●

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Good ●

Is the service well-led?

The service was not always well-led

Details are in our well-led findings below.

Requires Improvement ●

Angels Care At Home Ltd

Detailed findings

Background to this inspection

The 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 checked 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.

Inspection team:

This inspection was carried out by one inspector, one assistant inspector and an Expert by Experience. 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:

Angels Care at Home Limited are a domiciliary care agency (DCA). The service provides personal care to people living in their own houses and flats in the community. There was a registered manager. 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'. 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.

Notice of inspection:

This inspection was announced and took place on 17, 20 and 23 January 2020. We gave the provider 48 hours' notice of the inspection visit because we needed to be sure the management team would be in the office.

What we did:

Before the inspection we reviewed the information, we held about the service and the service provider. We did not ask the registered 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 looked at notifications received from the provider. A notification is information about important events which the provider is required to tell us about by law. We sought feedback from the local commissioners. We also reviewed the provider's previous inspection reports. We used all of this information

to plan our inspection.

During the inspection: On day one of the inspection we contacted four relatives to obtain their feedback and we received feedback from two relatives.

On second day of the inspection we carried out the office site visit. We looked at records, which included five people's care records. We checked recruitment, training and supervision records for two staff. We looked at a range of records about how the service was managed. We also spoke with the registered manager, operations manager, the care co-ordinator, one senior carer and one carer.

On third day of the inspection we contacted eight people to gather their views about the care they received and spoke with seven people.

After the inspection

We contacted three external professionals to gather their views about the service.

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 remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

At our last inspection we found the recording issues around medicines. It was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- At this inspection we found the provider introduced an electronic system to record support around medicines. The system was set up in a way it was not possible for staff to mark the visit as completed if a task, such as assisting people with medicines had not been completed. The office staff monitored the system live. We saw examples of the new electronic records surrounding medicines and saw required information including the list of prescribed medicine was recorded. This included topical medicines, there was a list of when and where creams were to be applied to and the provider introduced body maps for reference. The system once fully implemented will aid the security and safety. This meant some improvements had been made but these needed embedding.
- Where people needed help with taking medicines they were supported to do so. Comments from people included, "(They) make sure that I've got my pills and check when I take them" and "They supervise my medication, record everything." A relative said, "They help to [person] to take medicines. [Person] would forget to take her medicines."
- Staff received training surrounding medicines and their competencies had been checked via spot checks.

Assessing risk, safety monitoring and management

- People's care records reflected where people had been identified as at risk. We saw examples of risk assessments and these included people's individual needs, such as skin integrity as well as their environment.
- We however found not all risk assessments had been updated. For example, one person used a hoist to transfer, but there was no moving and handling risk assessment completed. The care plan informed staff there was a hoist to use but did not contain detailed guidance on potential risks. We raised this with the registered manager who said, "I should have done the risk assessment". They told us that going forward all risk assessments will be recorded using the new electronic system and it will mitigate the reoccurrence.
- The provider had a business contingency plan that included various scenarios such as an outbreak or a loss of equipment.

Staffing and recruitment

- The feedback from people and relatives about staffing and punctuality varied. One person said, "Pretty much the only problem they don't turn up on time". One relative said, "On odd occasion there was a late call. They do try to provide consistent staff. Since Christmas [person] had different people." Two people told

us how they missed their planned appointments as a result of late visits.

- One staff member complimented how the scheduling recently improved. They told us a few months ago the rotas were not planned well, and they would often need to change it on the day. Another staff member said, referring to the new, electronic system, "We have a monitor and can see it live, we check it at the weekends, we look at it 3-4 times a day. You can see if they are running late etc. We're on top of it."
- The provider followed safe recruitment practices to ensure staff were suitable to work with adults at risk.

Systems and processes to safeguard people from the risk of abuse

- People and their relatives said people were safe. Comments from people included, "Quite confident that I'm safe, no problems at all" and "Very happy now I've got Angels in. I can quite honestly say Angels are the best agency ever. Go out of their way to look after you."
- The provider had a file with safeguarding concerns and we saw a number of concerns had been reported to the local authority safeguarding team. We however found no evidence of 'reviewing and learning from safeguarding (concerns) and sharing this learning with staff' as specified in the provider's policy.
- Staff knew how to escalate and report any safeguarding concerns. One member of staff said to us, "I'd speak to manager to discuss what needs to be done. External - I'd go to safeguarding website."

Learning lessons when things go wrong

- The lessons learnt had not been always learnt in a timely manner. We saw repeated entries in relation to missed visits had been recorded in staff meeting minutes in March 2019, May 2019 and November 2019. Since November 2019 the provider had implemented an electronic system which was now mitigating the risk of missed visits. Staff meeting minutes held in March stated staff had not always completed accident forms. The registered manager implemented a log of accidents. We saw ten accidents had been listed throughout 2019. However, we had been made aware about one person that had a fall and as a result sustained serious injury and this incident was not included in the log. It meant the log was not kept fully up to date and therefore the registered manager was unable to effectively monitor trends and patterns.

Preventing and controlling infection

- Staff had training in infection control.
- Staff had access to protective personal equipment (PPE). One staff member said, "Stock in the office".

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 the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance

At our last inspection we found concerns around records relating to MCA and we made a recommendation the provider sought current guidance on carrying out MCA assessments.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

- We found people's care records were not in line with good practice. For example, we found one person had a capacity assessment carried out for a decision around consenting to assistance with personal hygiene. The assessment was concluded with, "[Person's] [relative] makes all decisions for [the person]". The person's care file did not give details if the person's relative was legally authorised to make lawful decisions for the person in relation to their care and welfare. We asked a member of staff if they knew if the relatives had Power of Attorney and they said, "I don't think there is one". Another person had a capacity assessment completed without specifying which decision was being assessed. We showed the assessment form to the registered manager asking what decision was being assessed and they said, "Mental Health." The above meant we could not be reassured people's rights would be protected.
- People told us their choices were respected. Comments from people included, "They do ask for consent, never do anything without asking if it's alright to do something" and "Very good, asking me all the time before they help me."
- Staff knew how to apply principles of the MCA when supporting people. One staff member said, "Respect people's rights to make own decisions, everyone is an individual". Another staff member said, "Treat everyone as human being and always give them a choice".

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- People said where they had familiar staff the staff knew what to do. Comments included, "Carer has been with me for a long time, don't have to tell her what to do. Others very slow, can be an issue because

everything they do I have to tell them" and "One or two haven't got a clue. Have to ask them to do things for me, others good and will do everything."

- Staff had ongoing training relevant to their roles and told us they were well supported. A staff member said, "I had all training I required, and I am up to date".
- The registered manager planned to refresh their training and competencies in due course. This included their manual handling train the trainer course.

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

- The registered manager ensured assessments had been carried out prior to commencement of the service. They used the care planning template that covered people's physical, emotional and health care needs. Where applicable copies of the assessments with information about the length of the visits required were being obtained from commissioners. One relative said, "I've seen office staff several times before, (they) came to do an assessment." One person said, "(They) came in before the care started, sat down with myself, son and daughter -in -law and had a chat. Told them what I needed before taking me on".
- The template prompted a number of areas to be considered, such as people's communication needs and the details around people's oral hygiene needs.

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

- People's care plans included details of people's preferred food and the assistance they needed around meal times. One person's care plan stated the person liked to have, "Two slices of toasts ensuring butter is spread to the edges and cut in quarters."
- People told us about the support they had around meals. Comments included, "Porridge every morning, (they) put it in for me. I do all the rest of my meals" and "(They) get my breakfast for me. I do the rest."
- The provider was in a process of looking into further training around food textures to ensure where people had swallowing difficulties the terminology used was in line with the current practice.

Staff working with other agencies to provide consistent, effective, timely care; supporting people to live healthier lives, access healthcare services and support

- People told us staff supported them with accessing health services. One person said, "If they notice that anything is wrong report it and get the district nurse out."
- People's care plans highlighted where a specific external professional, for example a district nurse needed to be alerted if concerns identified.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People said staff were caring. One person said, "Never had a carer in here who has the miseries. Cheerful hello from all of them. Never had any trouble."
- People's relatives were positive about the care. One relative said, "They've been ok. They do their best generally." One professional commented, "I have been working with Angels Care at Home for the past few years. The members of staff are helpful and polite, always addressing problems with compassion and professionalism."
- Staff were committed to deliver good quality care. One staff member said, "I wouldn't work somewhere if I wouldn't be confident I would like my parents being there."
- The provider and the team were committed to respecting people's diversity. People's care plans contained a section around people's religious and cultural preferences.

Respecting and promoting people's privacy, dignity and independence

- People's dignity was highlighted in care plans and identified as an outcome they wanted to achieve.
- People commented their dignity was respected by staff. Comments included, "Good with dignity and respect. The way they treat me and speak to me."
- The provider protected people's confidentiality, people's records were kept secure and we saw staff used own logins when accessing electronic records.

Supporting people to express their views and be involved in making decisions about their care

- People told us how staff involved them in the care. Comments included, "Manager comes out to do checks. Can talk about care plan and anything else. Can get extra care if needed."
- Staff appreciated the importance of involving people and we saw people's care plans were written in a person-centred way, as if these had been written by the person. For example, one person's care plan said, "I would like to eat in my chair in my lounge."
- People's relatives told us where relevant they had also been involved and kept updated. One relative said, "If there are problems they phone me."

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question remained the same. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences.

- People told us they had the care that met their needs. Comments included, "If I want something done out of the ordinary, they will do it, such as putting the little Hoover round." and "They (carers) do their best when they are helping me. I said I need a [piece of equipment] so they're arranging for me to have one. Absolutely carers are first class about my care."
- The new system used for care planning enabled staff an ongoing access to people's care plans and the office team were able to monitor the entries made by staff in a real time.
- People's care records were detailed and included people's life history, their likes or dislikes and their health conditions as well as impact it had on people's abilities. People's care records also outlined the outcomes people hoped to achieve during their care visits. For example, one person wanted 'my carer to give me a full body strip wash in bed every morning'.
- The feedback from an external professional was positive, they described an example where the service achieved good outcome for the person. They also said, "In my professional opinion, Angels Care at Home have been working with person centred approach."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's communication needs were assessed and recorded in people's files. This included information about how to assist the person with effective communication. One person's care plan said, "Hearing; please be patient when talking to me and speak clearly." One relative said, "[Person] is hard of hearing but is orientated, they all know to write things for [person]."
- Staff were aware of people's needs and had appreciation how to enable people good communication. A staff member told us how one person would often eat food using their hands and then smudge their glasses and how they ensured they wiped the person's glasses.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People's care plans included a "What's important to me" section which includes information about people's family and important relationships. One person's record said "My wife and son" were important to them. There was also "Any concerns or difficulties and the impact that these have upon me" and the same person's care plan said, "I am concerned I won't be able to live at home."

- People's care plan also reflected people's social events, hobbies, things they liked to do and any pets.

Improving care quality in response to complaints or concerns

- Information how to complain was available. People knew how to complaint. One person said, "I know how to complain – would phone the office." Another person said, "I have complained and they have sorted it out."
- The registered manager kept a log of complaints made and we saw these were responded to. An external professional said, "From my experience, service users and their families usually give a positive feedback about Angels Care at Home and when there is an issue, the staff are keen to find a solution and get things right in a professional way and in timely manner."

End of life care and support

- No people received end of life care at the time of our inspection visit. The registered manager confirmed staff would work with other professionals if needed to ensure people had pain free and dignified death.

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 remained the same. This meant the service management and leadership remained inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred 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 we found the provider did not always had effective systems to assess, monitor and improve the quality and safety of the services and did not always maintain accurate records. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- At this inspection we found the provider made some improvements. For example, they implemented a brand new, electronic system for care planning and scheduling. There was an ongoing work to improve people's care documentation and the feedback from staff reflected the use of the new system significantly helped with accessing the information. The use of hand-held devices allowed an instant access to people's records and staff reported improved communication.
- The provider, who was also the registered manager was open, honest and acknowledged the improvements still needed to be made. We saw a copy of the provider's action plan compiled following the commissioners' contract monitoring visit earlier this month where a number of areas for improvement had been identified.
- The provider acknowledged they failed to keep a good overview of the missed visits log throughout the last year. A staff member said, "We only started spreadsheet this month".
- The provider's own quality assurance policy had not always been promptly followed and the quality assurance system had not been fully effective. The registered manager showed us examples of care files audits they carried out and we saw the audit did not include the risk assessments. This meant they would not be able to identify what we found that the risk assessments had not always been updated in a timely manner.
- We also found the action taken to address previously areas of concerns had not always been taken in timely manner. Despite the recommendation we made at our last inspection around Mental Capacity Act the registered was still to refresh their training and competence.

The above issues were a repeated 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 and other regulatory requirements

- We found the provider did not always submitted statutory notifications to us. They failed to notify us

about an allegation of abuse and a serious injury.

- The Care Quality Commission (CQC) sets out specific requirements that providers must follow when things go wrong. This includes informing people and their relatives about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The registered manager communicated with people and their relatives where required.

This demonstrates a breach of a breach of Regulation 18 of the Care Quality Commission (registration) Regulations 2009.

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

- The provider run a satisfaction survey. We saw the summary results of the survey run in August 2019 and found it was not clear what action had been taken to act on people's feedback. For example, the summary read, "There are some occasions where it has been reported that the communication isn't great with the office. This doesn't happen often, appreciate it can be frustrating and we are working towards rectifying this." There was however no information what action had been taken and how it had been measured if effective. One person's review carried out three months later, stated the person experienced 'a very unprofessional approach' when contacting the office. This meant the action taken had not always been effective.
- People's views were being gathered via reviews. The senior team including the registered manager also all delivered hand on care and this gave them an opportunity to receive feedback on an ongoing basis.
- The provider used spot checks during which people also had been asked for their views.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people. Working in partnership with others

- The team were committed to improving the service. The registered manager told us they experienced difficulties with the office staff last year and said, "I had to let them go". They added, referring to the concerns they identified, "That won't happen again".
- People's comments about the how the service was run varied; "As far as possible good. Couldn't ask for better" and "Happy with thing and how it runs apart from the time-keeping."
- The staff said that team work improved. One staff member said, "It's nice, because in the beginning staff never used to come in to the office, rosters were hit and miss. In last 8-9 weeks staff are coming in, having a chat, it's an open house policy, culture is a huge improvement."
- Staff worked with others such as commissioners and external professionals. One professional commented, "Engagement could be better."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to submit all statutory notifications.
Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure people's care records were in line with MCA Code of Practice.
Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure their quality assurance processes remained effective.