

A New Angle Ltd

A New Angle Ltd (York)

Inspection report

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Ratings

Overall rating for this service	Inadequate ●
Is the service safe?	Inadequate ●
Is the service well-led?	Inadequate ●

Summary of findings

Overall summary

About the service

A New Angle Ltd (York) is a domiciliary care service providing care and support to people with a range of support needs living in their own homes. There were 14 people being supported with personal care at the time of our inspection.

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 and what we found

The safe running of the service was directly impacted by a lack of financial resources/management. There was no provider oversight and operational issues put people and staff at risk. This included, late payment of staff wages and non-payment of office utilities.

Numerous staff had left the service due to ongoing payment issues with the provider, this included the newly recruited manager. The provider did not respond to requests we made about the management oversight for the service. Staff who continued to work at the service felt unsupported.

Risks to people were not appropriately assessed, mitigated or reviewed. At the last inspection we recommended the provider reviewed the COVID-19 risk assessment, no action had been taken to address this.

We could not be sure that medicines were being safely administered as prescribed due to various system failures such as gaps in recording and missing information.

The provider had taken no action to address the concerns we found at the last inspection. The provider was not open and honest during this inspection and failed to respond to requests from the inspection team.

Quality assurance systems in place had not been updated, reviewed or completed. The provider did not monitor the service fully and systems in place did not identify the shortfalls we found during the inspection.

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.

Staff working at the service had a good understanding of how to keep people safe.

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

Rating at last inspection and update

The last rating for this service was requires improvement (published 10 June 2021).

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected

We received further concerns in relation to provider operational and financial issues. This included staff not being paid on time and a lack of working equipment to enable staff to provide safe care. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this report. You can see what action we have asked the provider to take at the end of this full report.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to risk to people, medicines, infection prevention and control, governance, financial position and keeping the statement of purpose for the location up to date. Please see the action we have told the provider to take at the end of this report.

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

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement

procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate ●

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate ●

The service was not well-led.

Details are in our well-led findings below.

A New Angle Ltd (York)

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team

One inspector visited the office location on 4 October 2021.

Service and service type

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided. The provider had recently recruited a new manager who had been in post for one month, however, they left during the inspection.

Notice of inspection

This inspection was unannounced.

Inspection activity started on 4 October 2021 and ended on 19 October 2021. We visited the office location on 04 October 2021. Further inspection activity was completed via telephone and by email, which included speaking with staff and reviewing additional evidence and information sent to us

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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we

inspected the service and made the judgements in this report.

During the inspection

We spoke with three members of staff including the manager and care coordinators. We reviewed a range of records. This included three people's care records and two people's medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection

We requested contact details for care staff, people and their relatives to receive feedback about the service. We did not receive the requested information and were unable to gather staff, people and relatives' views on the service. We contacted the nominated individual to seek further assurances regarding the stability of the service. They did not respond. The nominated individual is responsible for management of the service on behalf of the provider.

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 deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Preventing and controlling infection

At our last inspection we recommended the provider consider current guidance on COVID-19 risk reduction and awareness, Personal Protective Equipment (PPE) practices and to update their practice accordingly. The provider had not made the required improvements.

- Risk assessments for COVID-19 safety remained the same. No updates had been completed and they were not in line with the most current guidance. The wrong advice in relation to the correct PPE staff should wear was recorded.
- Staff did not complete COVID-19 testing in line with government guidance. Staff told us "We do not complete PCR testing weekly, just Lateral flow tests twice a week."
- We requested a copy of the most up to date COVID-19 policy, but this was not provided. Therefore, we could not be assured that this was up to date and reflected the recent changes in government guidance.
- Fire safety procedures were not up to date.

Failure to properly assess, monitor and mitigate risks was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- We could not be assured that people received their medicines as prescribed. For example, gaps were identified within Medication Administration Records.
- Medication audits had not been completed since June 2021. Staff said this was because they did not have the appropriate documents or tools to complete these audits.

Failure to ensure the safe administration of medicines was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Care plans reflected people's abilities in managing their medicines. Staff had detailed information on how to support people to receive their medicines as prescribed.

Staffing and recruitment

- There was a small number of staff working at the service. The service had recruited two new staff members. However, applications to the disclosure and barring service (DBS) were not made which prevented these staff from starting their employment.

- Some staff said they were considering alternative employment due to the providers unreliability in paying their wages.
- The system used to support the monitoring of calls was not working. Contingency plans were in place to cover staff shortages and sickness.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- Staff had a good understanding of safeguarding practices and knew what action to take to ensure people were safe and protected from harm and abuse.
- There was no evidence of staff monitoring accidents or incidents to learn lessons when things go wrong. Staff told us there had been no accidents and incidents recently.

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 deteriorated to 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider had failed to operate effective quality assurances systems and properly assess, monitor and mitigate risks at the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The safe running of the service was directly impacted by several operational issues including delayed payment of staff wages and the non-payment of essential utilities at the office. This was putting people's care and staff at risk.

The failure to ensure you have the financial resources needed to provide and continue to provide the services to the required standards was a breach of Regulation 13 of the Care Quality Commission (Registration) Regulations 2009. Financial Position.

- Quality monitoring audits were in place. However, these had not been completed since July 2021. The manager stated that they did not have time to complete these as they were constantly dealing with staff, finance and operational issues.
- During the inspection the manager left, and no management support was put in place for the service. The provider did not have any oversight of how the service was performing.
- We sought assurance from the provider in relation to the management and oversight arrangements in place, but they did not respond.
- The provider had failed to provide their policies and procedures for review.

The provider failed to ensure the service was effectively monitored for quality. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had not ensured the 'Statement of Purpose' for the location was up to date. A statement of purpose is a legally required document that includes a standard set of information about a provider's

service.

The failure to ensure legally required information was kept up to date and submitted to CQC was a breach of Regulation 12 of the Care Quality Commission (Registration) Regulations 2009. Statement of purpose. This is being followed up outside of the inspection process and we will report on any action once it is complete.

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; Continuous learning and improving care;

- The provider had not made any improvements identified from the previous inspection. The manager had left the service and the provider failed to be open and transparent about the issues found at this inspection.
- The provider had failed to display the current rating at the service.

This was a breach of Regulation 20A: Requirement as to display of performance assessments. This is being followed up outside the inspection process and we will report on any action taken once it is complete.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Where staff raised concerns with the provider, these were not acknowledged or addressed.
- We requested the contact details of people and relatives who used the service. These were not provided by the provider, so we were unable to receive feedback about the service and care people received.