Ms Andrea Mckie

# Angels Assisted Living Services

## Inspection report

Suite 1, 1st Floor Block 3, Commercial House, Princess Way
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Prudhoe
Northumberland
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Date of inspection visit:
17 December 2015
18 December 2015

Date of publication:
25 May 2016

## 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? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

Angels Assisted Living Services is a domiciliary care service providing personal care and support to people living in their own homes, in the Tynedale area of Northumberland. The service provides general care and supports people with health and social care needs and end of life care. At the time of our inspection there were 16 people using the service.

This inspection took place on the 17 and 18 December 2015 and was announced.

Under its registration with the Care Quality Commission (CQC) this service does not require a registered manager, as the provider of the service is an individual in day to day charge of operations. 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 spoke highly of the provider as did the staff who worked for the provider. People told us they felt safe and happy with the care workers who visited their homes and they believed the provider delivered a good service.

Policies and procedures were in place to manage the service; however we found these to be generic, basic and under developed. There was no system in place to record or monitor incidents of a safeguarding nature. We identified some incidents of a safeguarding nature which the provider had not recognised as safeguarding matters and therefore they had not reported them on to the local authority or CQC.

Staff supported people at home with their care needs and the service had assessed some risks. However, risks associated with personal care tasks had not always been assessed. There was evidence that reviews of people's care needs had taken place. We observed care workers assisted people to take their medicines safely; however the medication needs and risk assessment documentation did not always reflect the current support being provided.

People told us they didn't feel rushed by staff when they delivered care and staff confirmed that they had enough time to complete the tasks required and travel between each care call. The provider manually devised the rotas based on her own knowledge and experience of each individual's needs and geographical locations. We found the provider employed enough staff to manage the service effectively.

Staff files showed that when recruiting care workers, the provider had carried out pre-employment vetting checks, however, references were not always from a suitable person. Training was provided to care workers by an external training provider. We reviewed the assessments of learning contained in some staff files. We found that some staff were working unsupervised before their competency had been properly assessed.

CQC monitors the application of the Mental Capacity Act (2005). There was evidence to show that staff understood their responsibilities under this act and training related to this had been provided to care

workers. However, the service had not considered people's capacity during assessments of their needs or alternatively they had not sought information from the local authority when they received initial referrals.

People were supported by care workers to maintain a balanced diet. They told us that staff made nice meals and always offered them a choice. One person told us "X (care worker) helped me make a pasta bake for lunch". Staff had undertaken equality and diversity training and people told us that they were treated as an individual. Care workers understood people's likes and dislikes, although these preferences were not recorded in people's care plans.

People told us their care workers were caring, compassionate and treated them with dignity and respect. We observed care workers respecting people's privacy and their belongings when we visited people within their own homes.

The provider held information about complaints, compliments and comments, as well as accidents and incidents. We found this information was lacking in detail and the provider told us that no formal complaints had been received; only areas of concern. We found information in a care record which was a complaint. Although this had been investigated and an explanation given to the complainant, the complaint had not been identified as such and therefore was not recorded in the complaints file for monitoring purposes. The same incident should have also been raised with the local authority as a safeguarding concern but had not been.

The provider monitored the quality of the service by carrying out spot checks on care workers and an annual stakeholder survey. Although both methods were undertaken, the results were not collated and actions were not documented to address any shortfalls. Similarly, audits were carried out, but these were not robust and had not identified the issues we highlighted to the provider during our inspection.

The provider had a wealth of experience in care services and staff told us they found her supportive and approachable. Office staff told us they had been welcomed into the team and that the provider was more than happy to hear their suggestions for improvements to the service. The provider personally managed all of the daily operations and was in the process of handing over some responsibilities to the newly appointed administrative staff. The provider had a clear vision for the service and wanted to concentrate on improving and growing the business.

We identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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?

**Requires Improvement**

The service was not always safe.

People were not always protected from harm and improper treatment as the provider did not always recognise incidents as being of a safeguarding nature. There were no procedures in place to record and investigate safeguarding incidents.

The service did not recognise all risks associated with people's care needs and document preventative and control measures.

There was enough staff employed to manage the service; however, recruitment was not as robust as it should have been.

People told us they received their medicines in a safe and timely manner; however, documentation did not always reflect the correct support being given.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

We found that some staff were working unsupervised before their competence was properly assessed either through a thorough induction process or experience gained through an adequate shadowing programme.

The service had not considered assessing people's mental capacity, kept records about this or sought MCA assessments from the local authority.

Staff had a range of skills, knowledge and experience in care. They had regular opportunity to discuss issues or concerns with the provider through regular supervision, appraisal and staff meetings.

People were supported to maintain a balanced diet and they told us their care workers prepared nice food which was of their choice.

People's general healthcare needs were met and the service involved other health professionals when appropriate.

## Is the service caring?

Good

The service was caring.

Staff interacted well with people and displayed positive and caring attitudes. They understood people's needs and responded to these efficiently. Staff knew about people and their past lives.

Staff treated people with dignity and respect and had an understanding of equality and diversity. People told us their privacy was respected.

Staff were caring and compassionate and supported people well.

## Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records demonstrated people's needs were assessed. However, care plans were not person centred and risk assessments were basic in detail. Some care records contained out of date information.

A complaints policy was in place and the manager told us she had received no complaints or concerns. However, we reviewed complaints in people's care records which had been dealt with but not logged as a complaint for monitoring purposes.

People were aware of how to complain and said they would feel comfortable raising any issues that they may have with the provider directly, or their care workers.

## Is the service well-led?

Requires Improvement

The service was not always well-led.

Policies and procedures were generic and under developed. They were not service specific.

The provider did not demonstrate good governance. There was a lack of systems in place to monitor the quality and safety of the service.

Stakeholder surveys had been carried out; however the results had not been collated and subsequently no action plan had been devised to address any shortfalls.

The culture in the office was open and transparent. Staff told us

they enjoyed working for the provider and felt part of a team.

# Angels Assisted Living 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.

This inspection took place on the 17 and 18 December 2015 and was announced. The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to seek permission of people who used the service and let them know that we would be visiting them in their own homes. We also needed to be sure staff would be in the office to access records and support us where necessary.

The inspection team consisted of two inspectors and a specialist advisor. A specialist advisor is a person contracted by the Care Quality Commission to support inspectors during an inspection and provide specialist knowledge and input. The specialist advisor on this team had an extensive care management background and expertise in matters of governance.

Prior to the inspection we reviewed all of the information we held about Angels Assisted Living Services including any statutory notifications that the provider had sent us and any safeguarding information we had received. Notifications are made to us by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. They are records of incidents that have occurred within the service or any other matters that the provider is legally required to inform us of.

In addition, we contacted Northumberland local authority contract monitoring team and adult safeguarding team to obtain their feedback about the service. All of this information informed the planning of the inspection. On this occasion, we did not ask for a Provider Information Return (PIR) prior to the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

As part of the inspection we visited three people in their own homes. We also spoke with people's relatives to gather their views about the service, two care workers, the office manager, the administrator and the provider. We reviewed a range of records related to the management of the service. This included looking at three people's care records, nine staff files and a variety of policies and procedures.

Requires Improvement

# Is the service safe?

## Our findings

The provider told us that there had been no incidents of safeguarding in the past 12 months. However, they proceeded to tell us about an incident currently being dealt with, which was of a safeguarding nature. We discussed another safeguarding event with the provider, who was not entirely aware it had occurred, and which had not been notified to either the local authority safeguarding or CQC. The office manager was able to tell us more about this incident from notes made on the computer. We found evidence in people's care records of other incidents which had also not been considered as safeguarding, but they were in fact incidents of a safeguarding nature. Although the provider had 'Accidents and Incidents' and 'Complaints, Compliments and Comments' files in place, there was no separate file set up for monitoring safeguarding concerns. The provider told us that to her knowledge there had not been any accidents within the service.

There was no service specific safeguarding policy or procedure in place. The provider was using a generic policy but this was unclear about staff's responsibilities in the event of a safeguarding incident and who they should raise a concern with if necessary. The provider told us that care workers were aware of their responsibilities as she informed them during induction and through staff meetings to inform her if there are any concerns about people. The staff we spoke with confirmed they had received training in the safeguarding of vulnerable adults and were aware of their personal responsibility to report matters of a safeguarding nature. They displayed they had knowledge of the different types of abuse people could be exposed to and the channels through which they should report any concerns that they may have. Although, we had identified minor incidents these had not been shared with the local authority for recording and information purposes. We discussed the importance of this with the provider and they assured us that in the future they would discuss such matters with the local authority as part of their decision making.

However, the provider did not have effective systems in place with regard to safeguarding to identify any concerns and respond appropriately to this. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.

The provider had policies in place to manage risk and safety; however these were based on a generic package named 'Quality Compliance System'. They were not service specific and had not been tailored to meet the needs of this service. They were limited and under developed. They contained information about what a policy should include, but had not been rewritten with the service or the people using the service in mind. One policy document recorded it was last updated on 1 June 2012. A copy of a safeguarding policy was observed in a person's care record stating it was last updated on 1 October 2015, however this contained out of date information relating to legislation.

People's care needs were assessed and risk assessments were linked to these, however we found these to be basic and brief. Risks within people's own home environments had been considered and any moving and handling equipment used, but care plans were not specific enough and did not consider managing risks relating to the actual task being carried out by the care worker. For example, a person who required assistance to bathe had no risks documented associated with slips, scalding or toiletries. We reviewed the care records of a person who had been involved in several high risk incidents. The incidents had not been

documented in the person's care records and they also did not contain preventative or control measures associated with the risks; neither did they inform care workers of what to do if they encountered this.

We noted that none of the care files we reviewed contained information about managing risks associated with people's mental capacity, despite some people living with different levels of dementia.

People received assistance to take their medicines. We observed a care worker carried out this task with two people. Although the care worker carried out the task safely, we noted that care records were not as robust as they lacked specific instructions for care workers to follow. The care worker told us about the support required by one person with their medicines; however the same information was not recorded in the person's care records. This meant that a different, less knowledgeable care worker may not have known how to support this person correctly with their medicines. For example, cream was prescribed to be administered to a person; however, there were no instructions within the person's care records about where on the person's body to administer their cream. The care record contained a blank body map. This person had been assessed as lacking mental capacity to manage their own medicines and was not always able to instruct care workers about the support they needed. We discussed this with the provider who told us they would use the body maps to indicate where to administer cream in the future. We also informed the provider about another anomaly we noted between the Medication Administration Record (MARs) and the support being provided by care workers. The provider told us they would rectify this immediately.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment.

People told us they felt safe with the care workers who visited their homes. One person said, "We've had X (care worker) for a while now, she's a good girl" and "I feel safe with X (care worker); she is always happy and singing". Care worker rotas demonstrated that people received a consistent service with a core team of care workers supporting them.

We observed two care worker's rotas over a three month period. The service did not use an electronic rostering system as the provider preferred to devise these manually using their own knowledge and experience of the people using the service and the geographical area. We shadowed a care worker when they completed some of their daily visits. The care worker told us they had enough time to get between each person and that people received visits at the times they preferred. We found there was enough staff employed to manage the service. We noted that the provider attended to some care visits themselves. We discussed this with the provider who told us that when they were short staffed, they covered visits because of their personal knowledge of the person rather than sending someone who is unfamiliar with their needs.

We noted on a few occasions due to bad weather conditions, visits had not been made to people. This was documented in their care records on the next visit. We asked the provider about this during the inspection and she told us that due to the rural location of some people's homes, care workers had not made a visit in bad weather conditions. In these instances, the provider had contacted the person's relative to inform them of the situation. Again, this was a procedure the provider followed but there was no documented evidence of a business continuity plan. The provider told us they would develop a business continuity plan to ensure people were safe.

Staff recruitment was not as robust as it could be. Staff files contained evidence of pre-employment vetting checks such as an application form, references and Disclosure and Barring Service checks (DBS). The DBS check a list of people who are barred from working with vulnerable people; employers obtain this data to ensure candidates are suitable for the role to which they will be employed. We noted that employees had

not always supplied suitable referees. In six out of the seven care files we reviewed, there were anomalies with references. We discussed this with the provider who told us they would ensure referees were more suitable in any future recruitment.

Policies and procedures were in place for dealing with staff disciplinary action. Staff were given this information in their employee handbook and in their contract of employment. The provider showed us a recent disciplinary case that they were currently dealing with and we saw they were following the procedure set out in the disciplinary policy.

Requires Improvement

# Is the service effective?

## Our findings

The service had recently updated the structure of the staffing team. There was a Deputy Manager in place and two newly created senior care posts. In recent months the provider had also realised the need to enhance their administration processes and had created two further posts consisting of an office manager and an administrator. A team of care workers supported people in their own homes. These care workers had a range of skills, knowledge and experience in care work.

The provider worked with an external training provider who trained staff in topics which would help them to achieve the 'care certificate'. The care certificate is a benchmark for induction of new staff. It assesses the fundamental skills, knowledge and behaviours that are required by people to provide safe, effective, compassionate care. We noted that in some staff files, care workers had passed the 12 week deadline in which the care certificate should be achieved. This meant some staff were working unsupervised before their competence was properly assessed. We discussed this with the provider during the inspection. The provider assured us she would ensure that people were appropriately assessed and their competencies checked prior to the 12 week deadline in the future.

Although the provider and care workers told us there was a shadowing period, we did not find documentation in staff files to confirm this. In some staff files, a period of shadowing was dated, but there was no written record about the content of the shadowing experience and how well the care worker completed it. Therefore we could not be sure care workers had been properly assessed.

This is a breach of regulation 18, Staffing.

Records showed, and staff confirmed, that some more experienced staff were working towards higher care qualifications. A number of staff had completed a safe handling of medication course. They were also trained in other topics such as, dementia care, mental capacity act and catheter care.
There were supervision and appraisal processes in place and we observed this documentation within staff files. Care workers confirmed they received suitable supervision and appraisal with comments such as, "We get supervision every month and X (provider) is very good at getting us on courses". This meant staff were given an opportunity to discuss their role, any concerns they might have or any training and development needs they may have identified.

We saw minutes of a staff meeting which demonstrated the provider had used an incident involving a medication error as a learning opportunity. The provider had shared best practice guidance with care workers with a view to limiting a repeat incident.

The provider told us she was not aware of anyone using the service who was subject to any restriction of their freedom under the Court of Protection, in line with the Mental Capacity Act 2005 (MCA) legislation. We saw a comment in one care record regarding a relative having lasting power of attorney but there was no evidence of the official document to confirm this. An entry in another care record stated, "There is no doubt that X (person) has the capacity to agree to this care plan". However, there was no best interest's decision

recorded or any other documentation which referred to who and why this decision was made. This showed that information kept about people was not managed in line with current legislation and guidance.

The provider had not properly assessed people's capacity against MCA legislation upon initial referral and did not have copies of local authority mental capacity assessments for people who may have lacked capacity, such as people living with a form of dementia. This meant the provider could not be sure if people had any restrictions on their freedom or be fully aware of whether people lacked the capacity to make informed decisions. Completed and accurate records were not kept in relation to people consenting to their care and treatment. We discussed this with the provider who assured us she would contact care managers within the local authority and ask for copies of MCA assessments to support their own documentation, which would be immediately improved.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.

People told us their care worker ensured they had enough to eat and drink. We observed a care worker offered a person choice in line with their preferences. One person said "X (care worker) helped me make pasta bake for lunch today". A care worker told us they would always ensure people had 'essentials' like bread and milk in their homes. An entry in one person's daily note book indicated that a care worker had visited the local shops to purchase food items and the financial transaction was appropriately recorded.

The service supported people to maintain their health and wellbeing. Daily notes showed that care workers had reported concerns to the provider regarding people's general healthcare needs. We saw records which showed when care workers had contacted people's GPs or the district nurse on their behalf. One relative told us, "X (care worker) rang for a nurse and sorted out appointments for X (relative) when I was in hospital and couldn't help out".

The provider kept a monthly log for each person which showed how the service acted upon information received from care workers, regarding people's health and wellbeing. This showed that where necessary the provider had contacted external healthcare professionals such as district nurses or occupational therapists for input into people's care.

Good

# Is the service caring?

## Our findings

People told us they were happy with the care workers who visited their homes and that staff were kind, caring and friendly. People said they enjoyed good relationships with their care workers. One person told us, "X (care worker) comes – I've had him a while; he's a nice man". One relative told us "X (care worker) comes every day, she is nice and friendly". The people we visited also spoke highly of the provider, whom they all knew well.

We saw "thank you" cards in a file which included comments such as, "Thank you for all the care and attention towards X. We are very grateful" and "Thank you for the love and dedication, you have given us a new lease of life. There is too much in my heart to put on paper, though please know how much all you do is appreciated. You angels are the best carers".

During the lunchtime observations, we saw good interaction between the care worker and the people we visited. The care worker communicated well with people, especially those who had communication difficulties and they were very familiar with each person's routine. It was obvious that people were comfortable with the care worker and they had a nice conversation throughout the visit. We spoke with the care worker between each visit and they were able to tell us about each person's life history, their preferences and the level of support they required. During the inspection the provider also informed us about individuals; their history and their support needs.

People told us about their preference to have a male or female care worker and they confirmed the service had accommodated this. Care workers told us they didn't visit anybody with obvious diverse needs, but they were aware of people's individual needs, including health. For example, one person who had diabetes and had different needs related to this condition. We observed in staff files that the service had provided training in equality and diversity and had offered care workers the opportunity to train in other topics to help them gain a better understanding of the support they provided to people, such as end of life care and challenging behaviour.

Care records showed that wherever possible people had been involved in planning their own care and had consented to the support that was planned for them to receive. We saw people or their relatives had signed consent forms. People had also been given a 'Service User's Handbook' which contained information and guidance about the service and the support they should expect to receive. The handbook contained a 'service user' contract, guidance on company policies, a feedback form and information about advocacy. People told us that although their care worker supported them with some tasks, they were encouraged to do as much as possible for themselves. For example, we saw one person was encouraged to assist in the preparation of their meal by their care worker and they participated in this task. We also saw people take their own medicines after a verbal prompt from their care worker.

We observed people being treated with dignity and respect throughout the visits we made. People told us their care worker respected their privacy and that support was given in a compassionate and respectful way. During one visit, a care worker took a person into their bedroom to change their clothes, in order to protect

and promote their privacy.

At the time of our inspection, the service did not support anyone at the end of their life; however they were supporting people with terminal conditions. We saw evidence in staff files that care workers had received training in end of life care and dementia care. The service had a policy in place for end of life care and we saw evidence in care records that advance planning around choices about resuscitation had been addressed, where people had wished to express their preferences.

Requires Improvement

# Is the service responsive?

## Our findings

We reviewed three people's care records and also visited these people in their own homes. The care records in their homes contained a lot of paperwork which was not relevant to their individual needs. Within people's care records there were many blank assessment documents, such as food and fluid charts, continence charts and seizure charts, which made it unclear whether the person had a need and the forms weren't being completed, or they did not have a need.

We found assessments to be basic and brief. There was a lack of personal information about people, such as life histories, preferences, likes and dislikes. Assessments were generic and not person-centred. They were mainly task orientated and lacked information about a personal routine or preferences around how care and support was delivered. Risks were associated with some care needs but not all of the person's needs. We found anomalies in each of the three care records between the person's current care needs and the support being provided by care workers. Although some care records had been updated as recently as the 15 December 2015, information contained in two people's care records were still incorrect.

This is a breach of Regulation 17, Good governance.

The care worker we accompanied during visits to people's homes, told us they had the flexibility to provide a service to one person freely throughout the day. They told us, "X pays privately for one hour per day, but we can split this however it is needed throughout the day. For example, I might do 30 minutes at lunchtime one day but the next; I might only need 15 minutes and spend the extra time at the night call". This demonstrated that the service could provide a personalised service and that care workers had the flexibility within their rota to accommodate people's changing needs.

People also told us that the service was flexible in that the provider accommodated changes in order to meet people's needs with regards to hospital appointments and the cancelling of visits. One relative said, "When we go out, I just ring up and cancel that day – I take the medicine with me and they just update the file at the next call". We observed in the care record that there was a code for 'social leave' recorded on the MARs. The care worker had clearly documented that the person was out and that the relative had taken responsibility for the medicine.

The service had a generic complaints policy and procedure in place. It was not a service specific policy but rather an instruction on how to write a complaints policy and what should be included. The service name had been inserted in places. It also stated that it was last updated on 1 June 2012. There were no complaints or compliments logged since 23 July 2014. People we spoke to told us they knew how to complain and would not hesitate to do so if it was necessary. The procedure was also explained in the 'Service User's Handbook'.

Upon reviewing care records we identified more recent complaints that were filed in people's care records but had not been logged in the complaints file. These related to alleged missed care visits. The records demonstrated that the complaint had been investigated and a written explanation had been sent to the

complainant. On one occasion, the outcome had not satisfied the complainant but there was evidence that the provider had made further enquiries to try and resolve the issue. We discussed this with the provider who told us she would add this to the complaints log to ensure it would be included in the future monitoring of the service.

Care records kept in people's home's contained no information or documents which could be removed and transported with the person if they required emergency attention, such as an urgent hospital admission. However the provider and care workers knew enough information about people's care and support needs to be able to verbally tell a healthcare professional.

Requires Improvement

# Is the service well-led?

## Our findings

Governance systems were not effective and did not identify the concerns that we found at this inspection. Having reviewed the policies and procedures for the management of the service we found that these were limited and under developed. For example, they were generic but had the service name inserted throughout. Although the provider could tell us about information we required, record keeping was poor and specifically there was a lack of written evidence in areas such as incidents of a safeguarding nature, risk management, health and safety, complaints about the service and quality assurance.

Although there were some audits related to Medication Administration Records (MARs), the service lacked audits in most other areas. The quality of the service was being monitored through basic spot checks and care needs reviews; but these were not fully documented and action plans were not in place to address any shortcomings. This meant that people were not receiving a service which was being properly analysed for quality and safety. The provider told us they had created the office manager, administrator and senior care worker posts in order to address these issues and to improve the management of the service. The office manager and administrator confirmed that they were in the process of scanning paperwork and filing it electronically on the computer system. They said, "X (provider) is happy for me to make suggestions and changes where I feel necessary to procedures which could be more efficient".

It was evident that during or visits to people's homes that they were cared for and they told us they felt safe and were happy. However, the governance of the service which underpinned all of the fundamental standards was not effective enough to ensure that people received high quality, safe care. The provider agreed with the findings which we fed-back at the end of our inspection.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.

At the time of our inspection the provider was the responsible person in day to day charge of the service. There was no requirement on the provider's registration to have a registered manager in post, but the provider told us they were considering the implementation of this role to enable them to improve and develop the service further.

The provider was aware of their legal responsibility to notify us of certain incidents as specified in Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Our records showed that we had received a low number of notifications. We discussed this with the provider during the inspection and highlighted a small number of incidents we had come across which should have been notified to us and/or the local authority safeguarding team. The provider assured us they now fully understood what types of incidents constituted a notifiable incident and they would familiarise themselves again with the requirements of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

During the inspection, we found there to be an open and transparent culture within the office environment and we accessed all the information we required. The provider assisted us during the inspection by liaising

with care workers and people who used the service to assist us with our duties. Staff we spoke with told us they enjoyed working for the provider. Comments made included, "X (provider) has made me feel very welcome and part of the team"; "I have known X (provider) since 2012 and have always found them to be incredibly approachable and accommodating wherever they can"; and "I believe that X (provider) has the best interests of the services users in mind at all times and they will do whatever it takes to keep Angels a success".

We saw evidence in staff meeting minutes that they were used to communicate with staff and incidents which could be learned from were shared to encourage better practice.

The provider told us they actively sought feedback and listened to the views of the people who used the service. They informed us about an annual survey which they posted out to people and their relatives to give them an opportunity to feedback their views. A care worker told us they had seen a postal survey in people's homes. People also confirmed this. However, we noted the survey had been completed some time ago but the results had not been collated and therefore we could not gauge an overall opinion of people.

The provider had qualifications and experience in delivering and managing care services. They had a clear vision for the service and wanted to concentrate on improving the administration and management of the service and expanding the business further. The provider had recently agreed new contracts to provide a 'responder' service for people living in sheltered accommodation and was looking forward to developing the service further.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Risk assessments were not adequately carried out and risk involving personal care tasks had not always been considered.<br><br>Anomalies were found amongst medication records.<br><br>Regulation 12 (1)(2)(a)(b)(c)(g). |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Care workers were working unsupervised without being properly assessed as competent i.e. care certificate induction was not completed within 12 weeks and care workers were working unsupervised.<br><br>Shadowing periods were not suitably documented so as to understand if competency had been assessed.<br><br>Regulation 18 2(a). |

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<br><br>The providers understanding of safeguarding was not satisfactory. Systems were not in place to record, investigate and monitor safeguarding incidents.<br><br>Mental capacity assessments had not been properly considered by the service. Decisions had not been made in line with current MCA legislation or guidance.<br><br>Audits were not in place to monitor safety and quality adequately. Policies and procedures needed updating. Records needed attention.<br><br>Regulation 17 (1)(2)(a)(b)(c)(d)(e)(f). |

**The enforcement action we took:**

Warning notice