Angila Care 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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Angila Care Ltd is a domiciliary care agency providing personal care to people in their own homes. 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. At the time of our inspection there were 31 people receiving personal care.

People's experience of using this service and what we found
People were not always safe. People were at risk of harm as the provider had not identified, assessed or mitigated risks. Accidents and incidents were not recorded. Safeguarding incidents were not always identified and acted upon appropriately. Medicines were not managed safely.

Recruitment processes were not robust in checking people were safe and suitable to work in the service. People's care needs were not always met as staff were not deployed effectively. People and their relatives told us care calls were often late and staff did not stay the full duration of the call. This was confirmed in care records we reviewed.

Care records were not accurate, did not reflect people's needs and were not clear about the care to be provided on each call. Complaints and concerns were not recorded.

There was a lack of effective leadership and an ineffective governance structure which meant the service was not appropriately monitored at manager or provider level.

People and their relatives said the staff were lovely, friendly and polite. Staff said they enjoyed their jobs and felt supported by the office staff.

The nominated individual told us action would be taken to address the concerns we identified at this inspection.

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 (published 22 August 2019) and there were breaches of regulation. The provider did not complete an action plan after the last inspection to show what they would do and by when to improve.

Why we inspected
We carried out an announced comprehensive inspection of this service on 29 May and 11 July 2019. Breaches of legal requirements were found. We undertook this focused inspection to confirm they now met

legal requirements. This report only covers our findings in relation to the Key Questions Safe 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 changed from requires improvement to Inadequate. This is based on the findings at this inspection.

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

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, safeguarding, staffing, recruitment and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Angila Care 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 (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 carried out by 2 inspectors 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
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

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.

The registered manager resigned with immediate effect the day before the inspection.

Notice of inspection
We gave a short notice period of the inspection. This was because the service is small and we wanted to make sure the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 10 October 2022 and ended on 17 October 2022. We visited the location's office on 10 and 17 October 2022. We carried out telephone calls to staff on 17 October 2022 and we contacted families and relatives on 12 October 2022.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 4 people who used the service and 6 relatives about their experience of the care provided. We spoke with 4 staff including the deputy manager, the care coordinator, 2 care staff, a director and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. This included 6 people's care records. We looked at 3 staff recruitment files and a variety of records relating to the management of the service, including policies and procedures were reviewed.

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 requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

At our last inspection the provider had failed to ensure safe medicine management systems were in place. This was a breach of regulation 12(1) 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 12

- Medicines were not managed safely.
- Medicine administration records (MARs) indicated medicines had not been given on numerous occasions, with no reasons recorded for the omissions.
- Daily records showed staff were applying creams to people. However, there were no records or body maps to show what creams were being used, where they should be applied or how often.
- There were no records to show if the medicines dosage and frequency recorded on the system was accurate.
- Medicine care plans were not clear. There was no information to show where medicines were stored, or who was responsible for re-stocking. There was contradictory information for one person about who administered their medicines. Daily records showed care staff were administering medicines however there were no records to show what had been given.
- Medicines competency assessments had been carried out with staff however the records lacked detail. For example, no details to show where the assessment had been completed and no comments recorded just a series of ticks.

Systems were either not in place or robust enough to demonstrate medicines were managed safely. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks to people were not assessed or managed safely placing them at potential risk of harm.
- People's care records did not include individual risk assessments. For example, there was no moving and handling assessment for a person who required a hoist for all transfers. Another person had a history of falls yet there was no risk assessment in place.
- Environmental risk assessments had not been completed.
- Incidents had not been consistently recorded or acted on. The deputy manager confirmed there were no accident or incident reports. However, daily records showed accidents and incidents had occurred. The

information provided was very limited and did not show the action taken to mitigate the risks and protect people from further incidents occurring.

The lack of robust risk management processes meant people were not protected from harm or injury. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Safeguarding incidents were not properly managed, recorded and investigated.
● The provider failed to identify, investigate and report safeguarding concerns to CQC or the local authority. The deputy manager confirmed there were no safeguarding records. However, care records showed safeguarding incidents had occurred. For example, 2 people had unexplained injuries and a relative reported a serious medication incident.

The failure to safeguard service users from abuse and improper treatment was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● The call monitoring system was not effective as although an alert was raised if the staff member had not signed into a call, there was no alert if the staff member left the call early. Daily logs showed some staff were often forgetting to sign in on calls.
● People and relatives said calls were often late and they were not always informed. They said staff did not always stay the full duration of call. This was confirmed in the daily logs we reviewed. Comments included; "It fluctuates [arrival time]. [Staff] don't often stay the full time. About 10 minutes instead of 30 minutes. That is regular" and "[Staff] are sometimes late. I expect them at 11.00 to 11.30am. They once turned up at 1.15pm. They are quite often late" and "[Staff] should stay 45 minutes. Usually they stay for 30 minutes."
● There was no oversight or monitoring of the call logs by management, which meant when care workers were not staying the full length of the call, this was not picked up immediately.

Systems were either not in place or robust enough to ensure staff arrived on time and stayed the full duration of the call. This placed people at risk of not receiving the care they required. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we recommended the provider reviewed recruitment documentation to strengthen the recruitment process. The provider has not made improvements.
● Recruitment processes were not safe as checks to establish a candidate's fitness for the role were not suitable and sufficient.
● The provider is registered to provide personal care to children. Disclosure and Barring Service (DBS) checks were carried out however the provider had not requested full information to ensure both children and adults were protected.
● Application forms did not include a full employment history, there were no interview records and references were not always verified. There was no evidence to show car insurance documents had been checked for staff who were drivers.
● Employer reference forms with questions about working history were still being sent to people supplying a character reference. This had been raised at the previous inspection.

The failure to follow robust recruitment procedures placed people at risk of harm. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- Staff said they had received training in infection control and personal protective equipment (PPE). They confirmed they were provided with adequate supplies of PPE.
- People and relatives told us staff were using personal protective equipment (PPE) effectively and safely.

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 requires improvement. At this inspection the rating has changed 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.

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

At our last inspection the provider had failed to ensure there were robust systems in place to assess, monitor and improve the quality and safety of the service. 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 at this inspection and the provider was still in breach of regulation 17.

- People did not receive a service that was well-led. Significant shortfalls were identified at this inspection with similar concerns to those found at our previous inspection. There was a continued breach in relation to safe care and treatment and new breaches in relation to staffing, recruitment and safeguarding. These issues had not been identified or addressed through the provider's own governance systems.
- Following the first day of our inspection we informed the provider of our concerns and requested a response detailing the action they would take to ensure people were safe. We did not receive a response. We made referrals to the local authority safeguarding team.
- There was a lack of effective management and leadership. The registered manager left the day before the inspection. The registered manager had not been in the service on a full-time basis. The lack of management oversight had contributed to the shortfalls identified.
- There were no effective quality assurance systems in place. Some medicines audits had been completed, however, these were incomplete or undated or unsigned, it was not clear whose medicines had been audited and there were no actions. The provider was unable to locate any other quality audits
- Provider oversight and monitoring was ineffective in identifying and managing organisational risk. The system used for staff to log in and out of calls and record their notes was not monitored effectively. Records we reviewed were incomplete or lacked detail and there were no audits. This meant there were no assurances staff attended the calls on time or for the correct length of time.
- Care records were not accurate, did not reflect people's needs and were not clear about what care was to be provided on each call. The nominated individual told us they would be implementing a new computerised system.
- Services registered with the Care Quality Commission (CQC) are required to notify us of significant events and other incidents that happen in the service, without delay. During this inspection, we found the

registered person did not ensure CQC was consistently notified of reportable events. This meant we could not check appropriate action had been taken to ensure people were safe at that time.

At our last inspection we recommended all concerns were logged so they could be analysed for any emerging themes or trends. The provider has not made improvements.

● People and their relatives told us they had raised complaints and said these had been dealt with. However, the provider confirmed there were no complaint records. This meant we could not check how many complaints and concerns had been raised, if appropriate action had been taken in response and if there were any themes or trends.

We found systems to assess, monitor and improve the service were not sufficiently robust. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People and relatives spoke positively about the care staff. Comments included; "[Staff] are polite, lovely and [person] enjoys their company"; "In all honesty they are smiley but very young and don't have a lot of initiative. They just accept what [person] says and could be more proactive"; "We love them [staff] and wouldn't be without them" and "They are very nice. They make me tea, help me shower and are kind."

● A staff meeting held in August 2022 reminded staff to sign in and out and to stay the full length of the call and to record the reason why if any call was cut short. Our inspection highlighted the same concerns showing these issues had not been addressed.

● Staff we spoke with said they enjoyed the job and felt supported by the office staff.

● People and relatives said overall they were satisfied with the service provided although it was felt the timing and duration of visits needed to improve One person said, "The timing of visits is my bugbear. Half an hour is half an hour. The carers don't stay long. I'd score it 6 out of 10."

● We saw surveys had been completed by six people in September 2022 and all expressed satisfaction with the service.

Working in partnership with others

● Care records showed the service worked in partnership with health and social care professionals.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Effective systems and processes were not in place to protect people from abuse. Regulation 13 (1)(2)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment processes were not operated effectively to ensure staff were safe and suitable to carry out their role. Regulation 19(1)(a)(b)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not effectively deployed to meet people's needs. Regulation 18 (1)

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not assessed, mitigated or monitored. Medicines were not managed safely. Regulation 12 (2)(a)(b)(g)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were not in place to assess, monitor and mitigate risks to people or to improve the quality of the service. Contemporaneous, complete and accurate records were not maintained for each person. Regulation 17 (1)(2)(a)(b)(c)

The enforcement action we took:

Warning notice