Angels Care Halesowen Limited

Angels Community Homecare Services

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Overall summary

Our inspection took place on 12 and 14 January 2015. The inspection was unannounced.

The provider is registered to deliver personal care. They provide care to people who live in their own homes within the community. At the time of our inspection 29 people received personal care from the provider.

At our last inspection in May 2014 the provider was not meeting Regulation 10 which related to the assessing and quality monitoring of the service. Evidence that we gathered during this, our most recent inspection, showed that no improvement had been made. We found that the service was not well led and was not being run in the best interests of the people who used it.

The registered manager had left the service in December 2014. A registered manager is a person who has registered with the Care Quality Commission to manage

Summary of findings

the service. Like registered providers, they are 'registered persons'. 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. The provider had appointed a new manager who told us that they were in the process of applying for registration with us.

Some people and their relatives that we spoke with told us that the service was good. Other's told us that it was not good in that there was a lack of staff, a lack of communication for example, people did not always know which staff member was to provide their care that day, some care calls were late and others were missed completely.

The provider was not up-to-date with what was legally required of them regarding for example, the safe recruitment of staff and medicine management safety. We found that the recruitment processes placed people at high risk of harm by them being cared for by staff that had not been appropriately checked or confirmed as suitable to care and support them. We also found that medicines were not managed to a safe standard. Medicine recording did not confirm the actual medicines that were given or how many medicines the staff had supported people to take. We found that some care calls were late or had been missed completely. The poor performance of the provider in all those areas resulted in people being placed at risk of harm, being neglected and having some of their care needs omitted.

The provider told us that they had not carried out any audits. They told us that they had trusted the previous registered manager and had not undertaken any checks on the work that manager had done.

Low staffing levels placed people at risk of them not receiving the care and support they needed or not receiving their care and support at the right time.

We found that a complaints procedure was available for people to use. However, although we asked the provider a three times, they did not show us the complaint log in order for us to determine if staff had followed the complaints procedure. This meant that people and their relatives could not be assured that any dissatisfaction would be looked into or dealt with effectively.

Staff told us that were not adequately supported in their job roles. The provider confirmed that staff support mechanisms were lacking which included formal one to one supervision sessions for staff and staff meetings.

People told us that they had not been asked to complete feedback surveys, for example, about their experiences of the care that was provided or the overall quality of the service that they received.

People we spoke with told us that they felt safe. We saw that there were systems in place to protect people from the risk of abuse.

People who used the service described the staff as being nice and kind and our observations showed that they were. We saw that interactions between staff and one person who used the service were positive in that staff were respectful, polite and helpful to that person.

Staff told us that they were being provided with the training that they required. This would ensure that they had the skills and knowledge to provide safe and appropriate support to the people who used the service.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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.

Concerns and issues we identified during our inspection placed people at risk of neglect or having their known needs omitted.

Recruitment systems were poor and would not prevent the employment of unsuitable staff which placed people at the risk of harm.

Staffing levels did not ensure that people's needs would be consistently met.

Medicines were not managed to a safe standard. Medicine recording did not confirm the actual medicines that were given or how may medicines the staff had supported people to take.

Systems were in place to protect people and minimise the risk of them being abused.

Is the service effective?

Requires Improvement

The service was not effective.

Half of the people and staff we spoke with told us that the service provided was not effective.

Evidence that we gathered showed that the service provided was not always reliable so could not consistently meet people's needs or ensure their safety.

Some staff were aware of their responsibilities regarding the Mental Capacity Act.

Staff provided people with the meals they asked for.

Emergency situations were dealt with so that people received the attention they required.

Staff were receiving training to enable them to carry out their job roles.

Is the service caring?

Good

The service was caring.

People described the staff as being kind and caring and we saw that they were. They were polite to people and gave them their attention.

People's dignity and privacy were maintained.

People's independence regarding their daily living activities was promoted.

Is the service responsive?

Requires Improvement

The service was not responsive.

Summary of findings

People's needs and preferences were not regularly reassessed and care plans were not regularly updated.

People and their relatives told us that systems were not in place for them to voice their views and opinions.

Is the service well-led?

Inadequate

The service was not well-led.

The provider was not up-to-date with what was legally required of them regarding for example, the safe recruitment of staff and medicine management safety.

Audit systems had not been used to ensure that the service was safe and being run in the best interests of the people who used it.

The provider told us that they had not carried out any audits. They told us that they had trusted the previous registered manager and had not undertaken any checks on the work the registered manager had done.

Staff told us that they did not feel supported. Management support systems were not in place to ensure staff could ask for advice and assistance when it was needed.

Processes were in place for staff to report any concerns regarding bad practice which staff were aware of and told us that they would not hesitate to use.

The registered manager had left the service in December 2014. The provider had been quick to appoint a new manager who started work in January 2015.

Angels Community Homecare 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 12 and 14 January 2015 and was unannounced. The inspection was carried out by one inspector.

Before our inspection we reviewed the information we held about the service. Providers are required by law to notify us about events and incidents that occur; we refer to these as notifications. We looked at notifications that the provider had sent to us. Usually we ask the provider to complete a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about their service, how it is meeting the five questions, and what improvements they plan to make. However, due to concerns we received our inspection was not planned in advance so we were unable to request a PIR.

Our inspection was undertaken in response due to concerns that we had received regarding low staffing numbers, limited staff training and the absence of some staff pre-employment checks. Our last two inspections of May 2013 and May 2014 found that one regulation was not being met. This was because the provider did not have an effective system in place to assess and monitor the quality of service that people received. We spoke with the local authority contracting team who confirmed that in April 2014 they had suspended their contract with this provider due to care calls being missed. A suspension of contract means that the local authority would not fund any new people to receive a service from this provider. The local authority contracting manager told us that the suspension was still in place at the time of our inspection. We used the information we had gathered to plan what areas we were going to focus on during our inspection.

At the time of our inspection 29 people received personal care from the provider. Of those 29 people the local authority funded 19 peoples care. The remaining ten people paid for their own care. As part of our evidence gathering, with their prior permission, we visited one person in their home; we spoke with four people who used the service and three relatives by telephone. We spoke with seven staff, the acting manager and the provider. We looked at the care files for three people, medication records for two people, recruitment records for four staff who had been employed within the last year, the training matrix, complaints records and audit processes the provider had in place to monitor the service.

Inadequate

Is the service safe?

Our findings

During our inspection we identified concerns with regard to issues that placed people at risk from being neglected or having their known needs omitted. Issues we noted included unsafe recruitment practice, staff availability, and unsafe medicine practices.

Staff we spoke with and records we looked at identified that appropriate recruitment checks were not always undertaken to ensure that people were supported by suitable staff. We looked at files for four staff who had recently been recruited and found that for one, dates were not available to confirm there were no gaps in their employment history. The provider told us that they did not know why questions had not been asked about this. For one staff member the references obtained could not be confirmed as authentic.

For three staff an up to date Disclosure and Barring Service check (DBS) had not been requested. We spoke with two staff who confirmed that a new DBS had not been completed to date. For at least one of the staff, as they had previously only worked in children's services, no request had ever been made for a check to be undertaken on the adult barring list. All staff we spoke with and the provider confirmed that these staff had at times worked alone providing personal care to people. We identified that one new staff member had been allowed to 'shadow' in people's homes (shadowing is when new staff members may observe support and sometimes intimate personal care being provided by an experienced staff member for learning purposes). There was no application or current DBS no references or formal identity on file for this new staff member. The provider confirmed that these had not been received. The provider also confirmed when we asked that risk assessments had not been undertaken regarding the lack of current DBS's. The provider told us that they were not aware of the current requirements relating to DBS checks and thought they were all transferable. This showed that people were being placed at risk as checking processes to establish that prospective staff were suitable and safe to provide support and care for them had not been undertaken.

This is a breach of Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010.

People had mixed views about the reliability of the support provided to them. One person said, "They usually come on time. If they are going to be late they let me know". However, it was clear to us that late and missed calls had been experienced by a number of people. A person who used the service said, "They are late sometimes". Staff we spoke with told us that they were worried about the staffing levels. One staff member said, "We are always pushed. Many staff have left. Sometimes we have to work many hours over what we should. Last weekend I was late for a number of calls because I had so many". Another said, "It is bad now. In a few weeks two more staff are leaving. I do not know what will happen. We will not be able to fit everything in". This showed that the staffing numbers could not provide a consistent reliable, safe, service.

The provider confirmed that a number of staff had left, two others were leaving and that they had a staffing shortage. The provider told us that the new acting manager had been driving them [The provider] to people's houses because there were no other staff to provide those care calls. The provider told us that they were trying to recruit staff. They told us that they had placed adverts in a local newspaper, local shops and the job centre. On the first day of our inspection we highlighted that if staff were recruited now it would be some weeks before their pre-employment checks would be completed. On the second day of our inspection the provider told us that they would try and secure some staff from an agency.

Following our inspection we informed the local authority of our concerns because of the provider's history of missed calls. We told the local authority that the provider could not ensure that people would not be placed at risk as their staffing numbers were low and there was a lack of pre-employment checks for staff.

We had mixed views from people who used the service and their relatives about the arrangements the provider had in place to ensure the safe management of medicines. Staff told us that they had received medicine training. We saw certificates on their file to confirm that this was correct. One person said, "They help me take my tablets and I am happy with that". A relative told us, "I was really concerned. We saw that they did not give mum her medication correctly. One tablet was supposed to be dissolved in water but they gave it whole. They did not realise the implications of doing this on her condition". We asked the provider about this who had no knowledge of the incident.

Inadequate

Is the service safe?

The Medicine Administration Records (MAR) that we looked at did not give a precise account of the medicine staff had given to people or prompted them to take. For example, two MAR that we looked at did not give the name of the medicine or quantity given. They only specified 'Doss box' (This refers to the dossett box that the medicine was stored in). Staff we asked confirmed that a number of medicines were prescribed for those two people but they never recorded on the MAR what the medicines were or how many they gave or prompted people to take each time. Staff told us that all other peoples MAR did not have that detail either. We saw that there were some staff signature gaps in records and no reason why the staff signature was missing. This highlighted that the MAR in use did not confirm that people were being given/or prompted to take their medicine as it had been prescribed. We asked the acting manager about the process and showed them some MAR. The acting manager confirmed these should detail each medicine that has been prescribed.

The majority of staff told us that they had received moving and handling training which included hoist training. They told us that the provider had arranged for them to attend moving and handling/ hoist training sessions which was confirmed by training certificates we saw. This showed that safety practices were in place to ensure that people were not at risk from being injured by for example, hoisting equipment or unsafe moving and handling. However, one new staff member (who had not yet started to work alone or provide direct care) had received hoist training from another staff member whose 'Training the trainer' certificate for hoist training had expired. The staff member who had provided the training said, "My trainer's certificate expired some time ago". This was confirmed when we viewed the training certificate. We raised this with the provider who told us that they did not know that the training certificate had expired. This meant that the provider had not checked the quality of this training and could not give people who used the service assurance that they would be safe.

This is a breach of Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010.

All of the people we spoke with told us that they felt safe. They told us that they had not encountered any treatment or interaction from staff that they were worried about. One person said, "Oh yes, I feel safe with the staff. They have never done anything that has worried me". Another person said, "There may be problems but bad treatment is not one of them". A relative said, "No I am not aware of any concerns". All staff we spoke with told us in their view people who used the service were not at risk of abuse. All staff we spoke with told us that they had received training in how to safeguard people from abuse and knew how to recognise the signs of abuse and how to report their concerns. This showed that there were processes in place that the staff understood in order to protect the people who used the service from abuse.

Requires Improvement

Is the service effective?

Our findings

People and the relatives we spoke with had mixed views about the service provided. One person said, "There have been times in the past when things could have been done better, but overall I am happy with the service". Another person said, "I am not concerned about anything". A relative said, "Generally it is a good service". However, other people and relatives were not happy. One relative described the service as being, "Totally rubbish". They said, "We are thinking of changing to another service". A person who used the service said, "The communication is not good so messages do not always get through to the staff and things get missed".

One relative and two people told us that they did not always know which staff were to provide their care until they turned up and they did not like this. A person who used the service said, "No-one has told me yet which carer will be coming to me this evening. I would rather know". All staff we spoke with told us that they regularly had to swop calls to prevent care calls being missed. This did not give assurance that people could be provided with an effective service.

People did not comment on the staff's competence to support them to meet their needs. We found that there were some gaps in staff training. For example, not all staff had received food hygiene, infection prevention or dementia training. However, staff told us and showed us a training package that had recently been purchased. The training method was work books that staff had to work through and then they would be sent off for assessment. We saw that there were a number of elements that covered the training that staff had not received for example, food hygiene, dementia care and the Mental Capacity Act (MCA). Staff confirmed that they were presently working through the training.

We found that at least two new staff who had started to work alone and provide direct care to people had not received induction training. One staff member said, "I have to tell the truth. I was not given any induction training". The provider told us that they did not know why the staff had not received induction training. The lack of induction training meant that staff were not fully aware of how they should work and the policies and procedures that they should follow. This highlighted that the provider had not ensured that the staff were equipped to provide care safely or to consistently to meet people's needs.

At the time of our inspection the local authority had a suspension on the funding of new people in place due to the provider having a history of previous missed care calls. Evidence that we gathered from speaking with staff, people who used the service and their relatives highlighted that this issue had not been fully rectified. People who used the service told us that at times their care calls were late. One person said, "Sometimes they are late coming to me". Staff confirmed that due to low staffing numbers there could be no guarantee that care calls would not be missed or would not be late. One staff member said, "We try our best. If we are pushed we try and prioritise who is most at risk. This meant that other people's calls had been over half an hour late or more at times". This showed that the service was not consistently effective.

Although staff told us and records confirmed that a number of people had confusion or a diagnosis of dementia we did not see documentary evidence to confirm that people's capacity was assessed. We found by speaking with staff that their knowledge of the Mental Capacity Act (MCA) varied. Some staff had a good knowledge of the MCA, others had little or no knowledge of this. However, we saw that the training package that had been purchased included this training. People we spoke with and their relatives told us that staff encouraged them to do what they could for themselves and encouraged them to make day to day decisions.

All staff we spoke with told us that when there was a need they would support people to make doctor appointments and or access other healthcare professionals. This was confirmed by the relatives that we spoke with. Records highlighted and staff told us that the majority of people who used the service lived with or received support from a relative. Staff told us that when they identified that a person may be in need of assessment and or/treatment from healthcare professionals they would discuss this with the person and/or their relative for them to take action. The relatives we spoke with also confirmed that this was correct. This meant that where it was needed staff had taken the appropriate course of action to ensure that people's healthcare needs were met.

Requires Improvement

Is the service effective?

All staff we spoke with gave us a good account of what they would do if they found that someone was ill or they had injured themselves. They told us about recent incidents. One of which was they went to a person and found they had injured themselves. A staff member said, "I made sure that they stayed calm and phoned for an ambulance. I stayed with them until the ambulance came and phoned their family". This showed that staff were appropriately responsive in dealing with emergency situations.

The people and relatives that we spoke with confirmed that generally staff knew of people's dietary needs and risks if they were required to support people with eating and drinking. One person said, "I can only to eat certain things due to my condition. The staff know this and make sure that I am not given anything I should not have". One relative said, "They [their family member] are having problems with eating. The staff as far as I can see are managing this but I am going to ask for a review so that I can be sure". During a visit to one person's house we heard staff asking the person what they would like for their lunch. The person told us that staff asked them each meal time what they would like to eat. This showed that people's dietary needs and risks were being met by the staff.

Good

Is the service caring?

Our findings

People and their relatives described the staff as being, "Caring," and "Friendly." One person said, "The staff are kind". We observed one staff member's interaction with one person who used the service and saw that they were attentive and showed an interest in the person. The person said, "It is not because you are here they [The staff member] are always like that, they are nice".

It was clear from speaking to the people who used the service, their relatives and the staff that it was the care staff who had kept the service going for the last month. All staff we spoke with showed a commitment to the people who used the service. They tried their best to ensure that they received care and were as safe as possible. One staff member told us, "We have been juggling the calls and have been working long hours to prevent care calls being missed or late". Another staff member said, "We have been making sure as far as possible that the rota is covered. At times we have to prioritise who is most at risk and make sure that they get their calls on time. We have swopped days off and worked extra hours".

People we spoke with told us staff knew them and their needs well. Records that we looked at had information about people's likes and dislikes. This provided staff with the information they needed about people's preferences and gave them some understanding of their needs. All staff we spoke with were able to give some account of people's individual needs and preferences. One person said, "I like things done in a certain way. In the past there were problems with staff not knowing what to do. I am happy with the way staff care for me at the moment". This showed that the person's needs were being met.

We found that systems were in place to promote peoples dignity and privacy. People we spoke with confirmed that staff promoted their dignity and privacy. One person told us, "All staff, whichever one comes, are always polite". Another said, "They only do what I cannot. I like to be able to do things for myself and remain as independent as possible; they know this and let me do what I can". A staff member told us, "We encourage people do what they can. Our aim is to promote not decrease people's independence.

When we visited a person in their home we saw that they had been given an information pack. This contained information about the service and contact telephone numbers in case they needed to ring the service office to speak to a manager. One person said, "I think that information is old but my daughter rang the office not long ago for me and was able to speak to the manager". This showed that people had been given information to enable them to telephone the provider's office when they had a need to.

Requires Improvement

Is the service responsive?

Our findings

Before people were offered a service the staff ensured that they had enough information about them to know of and to meet their needs. We saw that care plans that had been produced by the local authority (who funded their care) were kept on the person's care file. This gave the provider the opportunity to determine if the person's support and care needs could be met. One person said, "It was some time since I started having care from these but I remember the staff did ask me a lot of questions to make sure they did things right".

People we spoke with told us that staff consulted them about their care and support and preferred routines. One person said, "They do talk to me about my support needs". Another person said, "When the staff come they talk to me about my care for that day". This showed that staff knew the importance of regularly asking people how they preferred to be cared for. However, records we looked at and staff we spoke with confirmed that formal reassessment of people's needs and care plan updates had not been completed for some time. The acting manager told us, "I have identified this is needed and I will address it".

People and staff we spoke with all confirmed that the provider had not used any formal methods to involve them in the running of the service and for them to voice their views if they wanted to. This was confirmed by the provider. A senior care worker told us that they sometimes visited people in their own homes to speak to them and their relatives to give them the opportunity to voice their views. They told us that they did not inform people and their relatives beforehand that they would be visiting them. This staff member said, "I do not make a record of these visits and the provider does not ask me about them". This meant that the provider had not taken appropriate steps to ensure that systems were in place for people and their relatives to make their views known about the support and service they received.

We saw that a complaints procedure was in place. People told us that they were aware of the process. One person said, "I would ring the office if I had a complaint". A relative said, "I complained to the staff who did not give them [the family member] their medicine properly. That should have been reported to the office and dealt with. No-one contacted me." We asked the provider three times to provide us with the complaint log. The provider did not give a reason for not providing this to us. This meant that we were not provided with sufficient information to determine if the provider was compliant with the law in respect of managing complaints processes.

People told us that the staff had been responsive to their particular situations. One person told us that they sometimes asked for a change of care call time and they dealt with that. They said, "If I have an appointment I may need to go out of my house early so I need my call earlier". This showed that the provider had been responsive to that person's personal situation.

Inadequate

Is the service well-led?

Our findings

Our Inspection of May 2013 found that the provider was not meeting the regulation regarding the quality monitoring of the service. Following that inspection the provider sent us an action plan informing us of how they would improve. In August 2013 we carried out a further inspection and found that improvements had been made and that the provider was meeting that regulation. However, our inspection of May 2014 found that the provider was again not meeting the regulation regarding the quality monitoring of the service. We could not find an action plan on our data base to confirm that the provider had sent us an action plan detailing how they would improve and they could not tell us what action they had taken to address the non-compliance with the law.

Our inspection found that the regulation was still not being met and the situation had worsened. We found that the regulations regarding staff recruitment were not being met; staffing levels were low and the provider could not give assurance to the people who used the service that their needs could be safely and consistently met. One relative said, "There are 'blips' at times. A few weeks ago we were missed a couple of times". We found that formal audits and checking mechanisms were lacking to ensure that staff were working as they should and that the views of people and their relatives had not been sought. The provider said, "I relied on the past manager to do that". The provider confirmed that they did not check work that was undertaken by the previous manager when they were in post. The provider told us that they had not had much involvement with the running of the service in the six weeks prior to the inspection.

The registered manager had left the service in December 2014. The provider had addressed this in that they had recruited a new manager who started to work at the service in January 2015. There was a senior care worker and a team leader. All staff we spoke with knew what their role and responsibilities were and were able to give us a good account of these. People and their relatives had mixed views about the leadership structure. One person said, "The owner (the provider) is good. I see them often". Other people did not know who the provider or the new manager were. One relative said, "I do not have much confidence in them".

The provider had reacted when the registered manager left by becoming more involved in the running of the service. They confirmed that they had not updated themselves on important issues for example, those relating to safe staff recruitment. They told us that they had not kept themselves up-to-date about what the regulations required them to do. They were unaware of our new methodology and ratings inspections and had not made use of the information available to inform them published by us. The provider also told us that they had not undertaken any quality monitoring. A relative and one person told us that they were not happy with the service provided.

We found that support systems were not in place for staff. Staff told us that the management team were, "Not very supportive". The provider confirmed that staff supervisions were lacking as were formal staff meetings. This meant that provider had not taken steps to ensure that formal guidance was given to staff or that mechanisms were in place for communication. One staff member said, "Communication from the owner (the provider) is not good".

This is a breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010.

The new acting manager told us that they had identified that there were a number of shortfalls and that they knew they had a lot of work to do. They said, "I will start working through my list to make sure that everything is corrected and is in place".

All staff we spoke with gave us a good account of what they would do if they were worried by anything or witnessed bad practice. This was confirmed by our evidence gathering. One staff member said, "If I saw anything I was concerned about I would report it to the provider. If I was not happy with their action I would go to social services". Another staff member said, "We have policies and procedures regarding whistle blowing. This showed that staff knew of the processes that they should follow if they had concerns or witnessed bad practice.

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 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The provider had failed to ensure that arrangements to ensure that service users were safeguarded against the risk of neglect and acts of omission which placed them at risk of harm.**

Regulated activity	Regulation
Personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The provider had failed to ensure that an effective system was in place to prevent the risk of unsuitable staff being employed.**

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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The provider did not have an effective system in place to regularly assess and monitor the quality of service that people received.

The enforcement action we took:

We issued a warning notice. This notice was served under Section 29 of the Health and Social Care Act 2008.