Mrs Tanya Michelle Upsall

The Angels on Call

Inspection report

106 Woad Farm Road
Boston
Lincolnshire
PE21 0EW

Tel: 07572592471

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14 September 2020
15 September 2020
16 September 2020
17 September 2020
22 September 2020
24 September 2020
29 September 2020

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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:
The Angels on Call is a domiciliary care service. It is registered to provide personal care to people living in their own homes in the community. The service operates in and around Boston, Lincolnshire.

Not everyone who used the service received personal care. The Care Quality Commission (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, 19 people were receiving a personal care service.

People's experience of using this service and what we found:
• There were significant shortfalls in organisational governance which increased the risk to people's safety and welfare. By her own admission, the registered person had failed to effectively audit and monitor the quality of service provision.
• The registered person had failed to schedule care calls effectively and ensure there were sufficient staff deployed to meet people's needs. The registered person had also failed to take proper steps to ensure staff employed were suitable to work in the service.
• There were shortfalls in the registered person's approach to assessing and managing risks to people's safety and there was little evidence of a proactive approach to organisational learning.
• Staff had not received some of the induction and refresher training the registered person had identified as mandatory. The registered person had also failed to ensure staff received regular supervision.
• Notifications about events that had happened in the service had not been submitted to CQC, as required in law.
• We identified concerns about aspects of the conduct and character of the registered person.
• More positively, current staff were generally satisfied with their experience of working in the service. Most people and their relatives also provided positive feedback on the caring, friendly nature of staff.
• The registered person had taken action to strengthen infection prevention and control measures in response to the COVID-19 pandemic.

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

Rating at last inspection:
The last rating for this service was Good (published 26 July 2019).

Why we inspected:
We received concerns about a number of issues including the management of people's medicines; the safety of staff recruitment; the scheduling of people's care calls and the management and administration of the service overall. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led only.

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

The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

Enforcement:
At this inspection we have identified breaches of regulations in relation to the assessment and management of potential risks to people's safety; the organisation of staffing resources; recruitment; organisational governance; the character of the registered person and notification of significant events.

In response to these breaches we took enforcement action against the registered person. Please see the action we have told the registered to take at the end of this report.

Follow up:
We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

Special Measures:
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 registered person's registration, we will re-inspect within 6 months to check for significant improvements.

If the registered person 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 registered person from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of 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 re-inspect it and 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.

The Angels on Call

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 checked whether the registered 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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak and to identify good practice we can share with other services.

Inspection team:
Our inspection was conducted by two 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:
The Angels on Call is a domiciliary care service, registered to provide personal care to people living in their own homes in the community.

The service was managed on a full-time basis by the owner who worked in the service on a daily basis, both in the office and delivering care. The owner was the registered provider with legal responsibility for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure the owner ('the registered person') would be in the office to support the inspection.

What we did before the inspection:
In planning our inspection, we reviewed information we had received about the service. This included information shared with us by other organisations including the local authority adult safeguarding team. We also reviewed notifications submitted to CQC. Notifications are events which happened in the service that the registered provider is required to tell us about.

During the inspection:
During our inspection we spoke with the registered person; four current staff members; four former staff; 19 current service users or their relatives and the relatives of two former service users.

We reviewed a range of written records including five people's care plan, five staff recruitment files and information relating to the auditing and monitoring of service provision.

After the inspection:
With the registered person's permission, we secured remote access to the provider's electronic call monitoring system and in the period 22 - 29 September 2020 conducted a review of the record of some people's care calls.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate.

This meant we were not assured that people were always safe and free from the risk of avoidable harm.

Staffing and recruitment
• In the five months preceding our inspection, the local authority safeguarding team had informed us they were investigating three cases of possible abuse by neglect of service users of The Angels on Call. All three cases centred on concerns about the safety of the provider's approach to the organisation of care staffing resources.
• At the time of our inspection, two of these investigations were ongoing but one had concluded in April 2020 with a finding of abuse by neglect against the provider. This finding reflected very significant concerns about the safety and reliability of the provider's deployment of staff to meet a particular service user's needs. Talking of this person, the registered person acknowledged, "I let [name] down."
• During our inspection, almost five months after the conclusion of this safeguarding case, some people told us of their concerns that there were still insufficient staff deployed to meet their needs. For example, one person said, "They can arrive on time some days but then others they can be anywhere up … to 40 minutes late. If they're more than an hour late, I get … on the phone to try and talk to [the registered person]." Another person had recently stopped using the service due to their dissatisfaction with the unreliability of their care calls. Commenting on this issue, their relative told us, "I just couldn't rely on them [to turn up as scheduled] to keep [name] safe."
• People told us that the provider did not always let them know if staff were running late, increasing their anxiety that their call might be missed and they would not receive the care they required. One relative said, "I think [my relative] would really appreciate it if someone was able to [ring] because … it must be at the back of their mind that someone might not turn up at all."
• Some staff also expressed their concerns. For example, one staff member told us, "Sometimes we are late … [because] … on the rota [we are down to be on two calls at the same time]. It happens a lot." Another member of staff said, "The rota needs sorting out. Sometimes it doesn't work out well. It gets tight [and] we get late for calls. [The registered person] helps out [but] she needs … bank staff [to cover staff absence]."
• The provider used an online system to schedule and monitor people's care calls. In the light of the recent safeguarding investigations and the feedback from people and staff, we extracted records of recent calls logged in the system. We found extensive evidence of late calls (defined by the provider as commencing more than 30 minutes after the scheduled start time), indicating insufficient staff were deployed to meet the needs of the people using the service. For example, in August 2020 one person experienced at least 16 late calls, seven of which were late by 90 minutes or more, increasing potential risks to their safety and welfare. When we discussed this issue with the registered person she acknowledged, "We've got to address late calls."
• We also identified a high incidence of 'call-clipping' ie staff staying for less than the scheduled call time,

increasing the risk of rushed, unsafe care. For example, in the three days 8 – 10 September 2020, of the eight calls to one person which had a start and end time recorded in the system, all were short. On 10 September, this person's scheduled 45-minute call lasted only 20 minutes. On the same day, a scheduled 30-minute call lasted only 14 minutes. In only three days, this person's recorded calls were short by a cumulative total of 131 minutes.
• We also identified that some care calls may have been missed altogether. For example, a relative of one person told us of five occasions in the period 13 June - 29 July 2020 when their relative's care calls had been missed. When we reviewed this person's call history in the online call monitoring system, we found no evidence to indicate these calls had taken place.

Almost five months after the local authority's finding of abuse by neglect, the provider was still failing to schedule care calls effectively and ensure sufficient numbers of staff were deployed to meet people's needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We reviewed recent recruitment decisions and found the provider had failed to use sufficiently robust processes to ensure that staff employed were of good character and suitable to work with the people using the service. For example, a Disclosure and Barring Service (DBS) check completed in February 2020 for one new employee listed 35 criminal convictions including common assault and theft. A DBS check completed in August 2020 for another new employee listed 19 convictions including actual bodily harm and theft. There was no evidence that the registered person had undertaken risk assessments to determine if either of these employees was suitable to work unsupervised with vulnerable adults, increasing the potential risks to people's safety and welfare.
• We found further significant shortfalls in the provider's recruitment processes which increased the risk of harm to the people using the service. The registered person told us her practice was to obtain two pre-employment references. However, of the five staff recruitment records we reviewed, 40% (two) had only one pre-employment reference on file. Additionally, we found that one new employee had been in post for over two months before the registered person applied for a DBS check.

The provider had failed to use sufficiently robust processes to ensure that staff employed were of good character and suitable to work with the people using the service. This was a breach of Regulation 19 (Fit and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong
• During our inspection we found the provider had failed to properly assess and mitigate a range of potential risks to people's safety and welfare in areas including care planning; medicines management; core training and organisational learning.
• We identified shortfalls in the care planning system which meant potential risks to people's safety had not been properly assessed, reviewed or monitored. For example, one person had been assessed as being at high risk of falls. A falls risk assessment had been completed in June 2018 but there was no evidence that this had ever been reviewed or updated, increasing potential risks to this person's safety and welfare.
• Staff provided this person with catheter care but there was no guidance on catheter care in the care file for staff to follow if, for instance, there was a blockage in the catheter or signs of infection. This was of particular concern as it was documented in this person's care file that they were prone to urine infections. Similarly, another person had been assessed as being at risk of developing skin damage but there was no guidance in place to advise staff how to manage this risk.
• Most of the care plans and individual risk assessments we examined had been reviewed on a monthly basis. However, most of these reviews appeared to have been cut and pasted from one month to the next,

with only the date having been changed. This was poor practice which further increased risks to people's safety and welfare.
• We identified shortfalls in the provider's management of people's medicines. For example, we reviewed medicine administration records (MAR) for one person and found recording gaps. We were unable to ascertain if this person had actually received some of their prescribed medicines as, in addition to these gaps on the MARs, there was nothing in the corresponding daily visit records to indicate the medicines had been administered.
• Some MARs lacked the detail necessary to enable staff to administer medicines safely. For example, one person's MAR described a medicine as 'cream for legs'. Neither the name nor dosage of the cream were listed, increasing the risk that this person might receive the wrong amount of medicine or the wrong medicine altogether.
• The registered person told us she conducted monthly audits of completed MARs and daily visit records to identify any issues, including gaps in recording. However, for the MARs and corresponding daily visit records we reviewed, there was no evidence to indicate that these audits had been completed or any action taken to follow up the recording errors we identified.
• We also found significant shortfalls in the provision of staff training and supervision, increasing the risk that staff might lack the up-to-date competence and skills necessary to care for people safely. The registered person told us that most mandatory and refresher training was delivered online. However, the contract with the online training provider had lapsed in November 2019 and had only been renewed a few days before our inspection. This meant staff had had no access to online training provision for over nine months.
• The registered person had no record of staff training and acknowledged that the lack of online training provision meant some mandatory training requirements were overdue, including some elements of induction training. This was confirmed by one member of staff who told us, "[I have been in post for several months but] I've not gone on any [online] courses."
• The registered person told us that she personally delivered moving and handling and medicines training to all new starters and assessed their competence before they started to work unsupervised. However, there was no completed medication competency assessment for one recent recruit who had started in February 2020 and who was administering people's medicines.
• The registered person also told us she aimed to offer staff one-to-one supervision every three months. However, we found significant gaps in the record of staff supervision. Of the 14 staff employed in the service at the time of our inspection, only five (36%) had had a recorded supervision in 2020. For one staff member there was no record of any supervision since October 2018.
• The registered person lacked a proactive or systematic approach to organisational learning from serious incidents and events, creating further potential risks to people's safety. For example, as described above, in April 2020 the local authority safeguarding team upheld an allegation of abuse by neglect against the provider. This case centred on the safety of the provider's approach to scheduling a person's care calls. However, despite the very serious outcome of this safeguarding case, nearly five months later the registered person had not properly assessed or mitigated the risks identified in this case and was still failing to deploy staffing resources safely to meet people's needs.

The provider had failed to properly assess and manage a range of potential risks to people's safety. Taken together, 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
• People told us they trusted the staff who came into their home. For example, one person said, "I've certainly got no reason not to trust them by how they have behaved since starting to provide me with support."
• However, the extended period without online training meant some staff lacked understanding of adult

safeguarding procedures, increasing the risk that abuse might go undetected or reported. For example, one recent recruit who was new to the care sector, appeared to have no understanding of the concept of safeguarding.

Preventing and controlling infection

• The registered person had reviewed and strengthened existing infection prevention and control measures in response to the COVID-19 pandemic. For example, staff had been provided with additional personal protective equipment (PPE). PPE remained in good supply and was being worn in accordance with national guidance. The registered person said she felt the COVID situation in the service was "under control for the moment" and was aware of how to access sources of support and advice when necessary.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate.

This meant there were widespread and significant shortfalls in service leadership and governance. 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; 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

• As part of our inspection we reviewed notifications that had been submitted to CQC. Notifications are events which happened in the service that the provider is required by law to tell us about.

• In April 2020 the provider failed to notify CQC of an allegation of abuse of a service user which had been investigated by the local authority under its adult safeguarding procedures. In June 2020 we raised this failure to notify with the registered person. She told us it was "… an error of judgement…" and that going forward she would "…learn from this and ensure any issues however small they may seem [are] report[ed] … [to] CQC…".

• Despite this assurance, during our inspection we found that the registered person had failed to inform us of a further two allegations of abuse of service users which had been investigated by the local authority in August 2020.

The provider's persistent failure to submit notifications of allegations of abuse was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

• There was no administrator employed in the service and the registered person told us that she and her deputy each worked hands-on for 30 to 40 hours each week "filling in gaps" on the care roster. This need to prioritise covering care shifts meant the registered person had insufficient time to discharge her management and administrative responsibilities, leading to a significant failure of organisational governance and multiple breaches of regulations. Acknowledging the inadequacy of her approach in this area, the registered person told us, "Clearly it's not working. I've not done [any] audits, the stuff I'm supposed to do."

• During our inspection site visit, it also became clear that the registered person was failing to use the online call scheduling system effectively to monitor the safety of care delivery. For example, she was unsure how to generate some management reports from the system and many care calls had no start or end time logged, limiting her ability to monitor the timeliness and duration of calls. Acknowledging the shortfalls in this important area, the registered person told us, "I don't use the call monitoring system very well."

• As a result of the registered person's failure to monitor the safety and effectiveness of service provision, the shortfalls in individual risk assessment and care planning; medicines management; deployment of staffing resources; recruitment; training and supervision and organisational learning described in the Safe section of this report had not been picked up or addressed. This created increased risks to people's safety and well-being.
• Additionally, at the time of our inspection there was an ongoing local authority safeguarding investigation of an allegation of financial abuse of a person who used the service. When we discussed this issue with the registered person, she acknowledged that the system she had devised to ensure the safe handling of people's monies was not operating effectively, increasing the risk of financial abuse. She told us, "Not all of the staff have completed the transaction sheet [used to account for any service user's monies handled by staff]. They know they should."

The provider had failed to assess and monitor the quality of the service and take action to address a wide range of potential risks to people's safety and well-being. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Current staff we spoke with as part of our inspection provided generally positive feedback about the registered person and her leadership of the service. For example, one staff member said, "Everyone loves [the registered person]. She is a fair boss." Another member of staff told us, "I think it's a good company to work for …. [although] the rotas need to be planned out … better. [The registered person] is always there to help."
• People who used the service and their relatives had more mixed opinions about the registered person's leadership. For example, one person said, "Things seem to be organised in … a scattergun way and I don't think [the registered person] is the most organised of people. But her heart seems to be in the right place and she does try her best." Another person told us, "I'd bring in someone to manage the service other than [the registered person]." Another person commented, "[The registered person] always been very approachable, friendly and always willing to help. But to be honest, she doesn't come across as the most organised person in the world to be running an agency."
• It was clear from this feedback that the registered person was generally well-liked by current staff, service users and their relatives. However, during the course of our inspection we became increasingly concerned about the registered person's character and fitness to carry on the regulated activity. These concerns centred on the registered person's honesty, trustworthiness and reliability.
• For example, on occasions during our inspection site visit, we found the registered person was contradictory and unreliable in her responses to our inspectors' questions. For example, she initially told our inspectors that she "always checks" completed MAR charts and daily notes "at the end of the month". However, when challenged that there was no evidence of these checks, she acknowledged, "I've not done any audits." Similarly, she initially told our inspectors that the online training contract had lapsed "about three months ago". We subsequently established there had been no contract for over nine months.
• The registered person told us she always obtained her own DBS checks before new recruits started work and did not rely on checks undertaken by previous employers. However, when challenged on this issue, she acknowledged that for one recent recruit she had relied on an out of date DBS check from another employer, before obtaining her own several months later. She also told us that there was no 'call-clipping' in the service. However, when we reviewed call schedules we found evidence to indicate this practice was prevalent.
• During our inspection we identified additional concerns about the registered person's conduct and character. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The concerns we identified about the registered person's honesty, trustworthiness and reliability and her

fitness to carry on the regulated activity constituted a breach of Regulation 4 (Requirements where the service provider is an individual or partnership) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff; Working in partnership with others
• The registered person was well-known to everyone connected to the service and people told us they would contact her with any queries or concerns. People had differing opinions on the response they received. For example, one person said, "We've always found [the registered person] to be very helpful whenever we've needed something from her." However, another person told us, "[The registered person]'s mobile phone … doesn't seem to have a voicemail facility, which I find very frustrating."
• The provider issued questionnaires to people and their relatives as another means of obtaining their feedback on the service. We reviewed some recently completed questionnaires and saw that feedback was positive. Apart from their concerns about call timings, most people we spoke with as part of our inspection were also generally positive about their experience of using the service. For example, one person told us, "The care they are providing is certainly what we need and the carers are all lovely." Another person commented, "We had two different agencies that we tried [previously] and … they're certainly, in our experience, better than the previous two."
• The registered person and her staff maintained a range of professional contacts with other organisations including GP's, community nurses and therapists.

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 18 Registration Regulations 2009 Notifications of other incidents The persistent failure of the provider to notify us of significant events which had occurred in the service.

The enforcement action we took:

We served a Fixed Penalty Notice.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The failure of the provider to properly assess and manage a range of potential risks to people's safety.

The enforcement action we took:

We imposed additional conditions on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The failure of the provider to assess and monitor the quality of the service and take action to address a range of potential risks to people's safety and well-being.

The enforcement action we took:

We imposed additional conditions on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The failure of the provider to use sufficiently robust processes to ensure that staff employed were of good character and suitable to work with the people using the service.

The enforcement action we took:

We imposed additional conditions on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 4 HSCA RA Regulations 2014 Requirements where the service providers is an individual or partnership Our concerns about the registered person's honesty, trustworthiness and reliability and her fitness to carry on the regulated activity.

The enforcement action we took:

We imposed additional conditions on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The failure of the provider to schedule care calls effectively and ensure sufficient numbers of staff were deployed to meet people's needs.

The enforcement action we took:

We imposed additional conditions on the provider's registration.