

A New Angle Ltd

A New Angle Ltd (Scarborough)

Inspection report

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Ratings

Overall rating for this service

Inadequate ●

Is the service safe?

Inadequate ●

Is the service well-led?

Inadequate ●

Summary of findings

Overall summary

About the service

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

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found

The safe running of the service was directly impacted by a lack of financial resources/management. Operational issues such as late payment of staff wages and non-payment of office utilities had put people and staff at risk.

The manager left during the inspection and the provider had no oversight of the service. Staff, relatives and stakeholders had lost faith in the provider due to persistent concerns about operational issues. Many staff had left the service due to ongoing payment issues with the provider.

The provider had not always been open and honest. Notifications about 'events that stop the service' had not been submitted when required.

Quality assurance systems in place did not monitor the service fully and did not identify the shortfalls we found during the inspection.

People's risks associated with health conditions were not risk assessed or care planned to support staff with action to take to support people. People were not protected from the risk of spread of infection such as COVID-19 as the service was not following up to date government guidance in relation to staff testing. The risk assessments and guidance to staff in relation to COVID-19 was also out of date and lacked detail.

We could not be sure that medicines were being safely administered as prescribed due to various systems failures such as gaps in recording, protocols missing and missing information. There was no records of accidents and incidents and no evidence of any lessons learnt.

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

Rating at last inspection

The last rating for this service was good (published 17 March 2018).

Why we inspected

We received concerns in relation to provider operational issues which resulted in a high turnover of staff. This included staff not being paid on time. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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

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

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

Enforcement

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

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate ●

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate ●

The service was not well-led.

Details are in our well-led findings below.

A New Angle Ltd (Scarborough)

Detailed findings

Background to this inspection

The inspection

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

Inspection team

One inspector visited the office location on 4 October 2021.

Service and service type

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

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

Notice of inspection

The inspection was unannounced.

Further inspection activity was completed via telephone and by email, which included speaking with staff and reviewing additional evidence and information sent to us. Inspection activity started on 4 October 2021 and ended on 15 October 2021.

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

During the inspection

We asked to speak to people who received a regulated activity or their relatives, about their experience of the care provided. No one was willing to speak to us as part of this inspection. We spoke with five members of staff including the manager, care coordinator, administrator and care workers. We reviewed a range of records. This included three people's care records and two people's medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection

We contacted the nominated individual to seek further assurances regarding the stability of the service. The nominated individual is responsible for management of the service on behalf of the provider. The nominated individual did not respond.

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 people were not safe and were at risk of avoidable harm.

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

- People's health needs were not risk assessed. Care planning lacked detail to guide staff on how to reduce people's health risks.
- People were not protected from the risk of infection. Staff were not completing COVID-19 testing in line with government guidance.
- Risk assessments in relation to the COVID-19 pandemic did not provide personalised information and were generic. They were not in line with the most current guidance and gave the wrong advice in relation to the correct PPE staff should wear.
- We requested a copy of the most updated COVID-19 policy, but this was not provided. Therefore, we could not be assured that this was up to date and reflected the most recent government guidance.

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

Using medicines safely

- We could not be assured that people received their medicines as prescribed as there were gaps in the recording of the administration of medicines. Information on the medication administration record was not always clear and did not reflect the prescription label of the medicine prescribed.
- People who had 'as and when' required medication or creams did not have protocols in place or body maps to guide staff on when or where to administer the medicine or cream.

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

Staffing and recruitment

- Staff were recruited safely with appropriate checks in place. However, gaps in people's employment history were not always considered.
- There was only a small number of staff working at the service. Several staff had left, and we were told more staff intended to leave. There were contingency plans in place to cover calls. These were being utilised on a regular basis. There was no current recruitment being undertaken due to ongoing financial issues.

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

- There were no systems in place to review and analyse accidents and incidents. Staff told us there had been no accidents and incidents recently. There was no evidence of learning lessons when things go wrong.

- Staff had limited understanding of safeguarding practices and what action to take to ensure people were safe and protected from harm and abuse.

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. 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

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

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

- Systems and processes were not operated to ensure the service was assessed or monitored for quality and safety in line with requirements. During the inspection the manager left and there was no management support in place for this service. We sought assurance from the provider in relation to the management and oversight arrangements in place, but they did not respond. The provider did not have any oversight of how the service was performing.
- Quality monitoring tools used did not highlight areas that needed improvement. For example, the medicine records where we found errors, had been audited with no issues identified. COVID-19 practices and risk assessments were out of date and were generic.
- The provider had failed to provide their policies and procedures for review.

The failure to operate effective quality assurances systems and properly assess, monitor and mitigate risks was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others

- The provider had not always submitted notifications about events that stop the service as they are required to do by law.

Failure to notify CQC as required was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. This is being followed up outside of the inspection process and we will report on any action once it is complete.

- Stakeholders had lost faith in the stability of the company.
- Information found during the inspection was not in line with what the provider had told us. The provider failed to provide assurances when requested as part of the inspection process.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

- Where staff raised concerns with the provider, these were not acknowledged or addressed. Staff were told not to contact the provider directly.
- People and relatives were asked to provide feedback to the provider in a survey. No analysis of this feedback had taken place. Feedback included, "The carers are good, but the office is badly run, and I don't feel listened to" and "It is imperative staff are properly paid and on time."