Angels Care at Home Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Angels Care at Home Ltd, referred to as Angels Care at Home in this report, is a domiciliary care agency registered to provide personal care to people living in their own homes. The service operates in Swindon and Hertfordshire. On the day of the inspection 13 people received regulated activity.

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

People told us they were safe. However, we found concerns around management of medicines. Staff told us the management team supported them well during the pandemic and ensured they had sufficient personal protective equipment in place.

People were supported to have choice and control of their lives and staff respected their rights to make own decisions. People's care records contained information of people's dietary likes and people had been supported with meals preparation when needed.

The provider's quality assurance processes remained ineffective and systems to monitor safeguarding concerns, accidents and care records needed improving. The provider did not ensure the necessary improvements had been made, sustained and lessons learnt where necessary.

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 10 February 2020) and there were breaches of regulations found. We issued requirement notices in relation to the regulations around the quality assurance systems, consent and the failure to notify us about reportable incidents. We agreed with the provider they will submit to us monthly updates about the progress made. The provider had not sent to us the evidence as agreed, for example, there was a gap of two months where we had received no updates. When we had an update, the evidence sent was not demonstrating sufficiently that improvements were being made. We had been receiving mixed messages about the improvements planned, of which some had not materialised.

At this inspection we found the provider was still in breach of regulation around good governance. This was their third consecutive breach of the Regulation 17 Good Governance.

Why we inspected
We undertook this focussed inspection to check the provider was compliant with the regulations and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions: Safe, Effective and Well-led, which contain those requirements. The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating

the overall rating at this inspection. The overall rating for the service remains requires improvement. This is based on the findings at this inspection. This is the third consecutive requires improvement overall rating for the service.

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

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.

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 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our safe findings below.

Angels Care At Home 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 Care Act 2014.

Inspection team
This inspection was carried out by one inspector.

Service and service type
Angels Care at Home Limited are a domiciliary care agency (DCA). The service provides personal care to people living in their own houses and flats in the community. There was a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the provider one day notice of the inspection. The office site visit took place on 25 November 2020.

What we did before the inspection
We reviewed information we had received about the service since the last inspection as well as the information shared with us by the local authority, such as details of the safeguarding concerns that had been raised. We used all of this information to plan our inspection.

The provider was asked to complete and returned to us 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.

During the inspection
On the first day of the inspection, which was the site visit we met the care manager and reviewed a range of

records. This included three people's electronic care and medicine records. We looked at three staff files in relation to recruitment and training. A variety of records relating to the management of the service including accidents and safeguarding records and audits were also viewed.

After the inspection
On the second day of the inspection we telephoned four staff, three people using the service and two relatives. We continued to seek additional evidence from the provider and requested further evidence around quality assurance systems.

Requires Improvement

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 requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Learning lessons when things go wrong

- The provider had been previously found in breach of regulations in relation to good governance on their last two inspections. Additionally, at the last inspection we identified a breach around the failure to submit the statutory notifications to us. At this inspection, we found repeated concerns in both areas. There was no evidence of learning from events to improve safety. This meant the provider did not ensure the necessary improvements had been made, sustained and lessons learnt where necessary.
- In their Provider's Information Return (PIR) submitted to us in March 2020 the provider said, "We have put a record sheet for lessons learnt, which will be updated throughout the year." At this inspection we reviewed the 'lessons learnt' folder and found it contained only one record. The record was dated September 2020 and related to a safeguarding issue that occurred at the start of July 2020 and was identified by a third party. The incident was in relation to unsafe recruitment practices and the record indicated recruitment practices had been improved to ensure they were safe and met the requirements of the regulations. At this inspection we saw there were still outstanding actions to ensure that staff files contained the necessary information.
- The service did not have a system in place to ensure they identified and acted upon safety alerts. These alerts require action to be taken by providers to reduce the risk of death or disability. There was no evidence of information, such as equipment or medicines alerts being received. When we asked the provider to provide evidence of these, they were unaware of their responsibilities to act on alerts.

Using medicines safely

- Where people had been prescribed medicines to be taken on 'when required' (PRN) basis, there was no evidenced process for staff to guide them. One person had been prescribed six different medicines to be taken on 'when required' basis and no information about when these needed to be administered were in place.
- People's care records did not always contain details of people's medicines. One person was prescribed a patch. There was no information in the person's care records what the patch was for and no body maps available to demonstrate the position of where the patch was being applied on the person's body. In addition, there was no information relating to where the patch position needed to be altered. We found out after the inspection it was a pain relief patch. The same person was prescribed another four forms of analgesia in tablets or a gel form. No information was provided in the person's care plans, if for example, all these medicines could be taken at the same time.
- There was no evidence staff competencies around medicines management had been carried out as required by the national good practice standards. This meant the provider did not ensure staff had the right skills to support people with medicines.
- The provider's electronic system was used to record the support people had around medicines. The

system's set up meant staff could not mark the visit as completed if a task, such as assisting people with medicines had not been completed. This meant the system enabled the service to monitor that people had received their medicines. A staff member told us this was being monitored and if a medicine was not given the system would flag an alert up.

Staffing and recruitment

● People and staff told us they had continuity of care and rotas were planned in advance. One person said, "As long as I have two regular ones (carers), I am very happy". A staff member told us they were given their work schedules weekly. They said, "Rotas (are) done in advance."

● Following a concern raised by a third party in July 2020 about the safety of the provider's recruitment process, they were in a process of auditing staff files. We saw a number of missing documents were recently requested and some actions were still outstanding to ensure that staff files contained the necessary information.

Assessing risk, safety monitoring and management

● People's care records contained information about their risks. For example, around their mobility and the use of equipment.

● People's safety in relation to their environment had been assessed.

● There was a business continuity plan in place that included what to do in various emergencies.

Systems and processes to safeguard people from the risk of abuse

● People and their relatives felt people were safe. Comments included, "She's safe with them, I trust them completely" and "(They) never let me down."

● The provider had a log of safeguarding concerns and we saw a number of concerns had been reported to the local authority safeguarding team.

● Staff knew what to do if they had a safeguarding concern. A staff member told us, "I had safeguarding (training) online, I would report to the office, take it from there and record, depending on the concerns (may need to report) to social care team in Swindon."

Preventing and controlling infection

● The provider had policies and procedures around infection control and Covid-19.

● Staff told us the management team supported them well during the pandemic and ensured they had sufficient personal protective equipment in place. Comments included, "We had enough PPE, had questions about Covid-19 and how it affects (us)" and "We had risk assessment when Covid-19 started. PPE always topped up, never run out."

● People told us staff wore PPE to prevent the spread of infections. Comments included, "Staff wear aprons, gloves and masks" and "PPE, they're very good about that."

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
At our last inspection we identified concerns around the provider's understanding of Mental Capacity Act and the Code of Practice. This meant we could not be reassured people's rights would be protected. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider addressed these concerns and no was longer in a breach of this regulation.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
We checked whether the service was working within the principles of the MCA.
● Since our last inspection the management team sourced and attended a training session around the MCA. The electronic system used for care planning had been amended to include capacity assessments if needed. However, we could not see examples of these documents being completed as none of the 13 people receiving regulated activity at present time required a capacity assessment.
● People told us staff asked them for choices and respected their wishes. One person said, "They do respect my choices."
● Staff told us, all people currently using the service were able to make decisions that related to the care and support they received. Staff knew how to apply the principles of the MCA when supporting people. One staff member said, "We need to assume people have capacity. Give (them) options." Another staff member told us how they would explain risks to people so people could make own informed choices.

Staff support: induction, training, skills and experience
● People said they had regular carers who knew them well. Staff told us, and records confirmed they had access to online e-learning training modules that included a number of areas such as nutrition, infection control or confidentiality. A staff member said, "I would like more training, for example, dementia training." The records of staff training were not always consistent. For example, one staff member with no prior experience in care only completed safeguarding training almost two months after they started delivering care to people. Their induction book, available on their training file was blank therefore there was no record of the induction being completed.
● The provider's staff supervision policy stated staff should receive supervision 'minimum four times a year'. We viewed files for three staff and none of them contained evidence the staff had received supervision in line

with the provider's policy. This meant the provider did not ensure staff were appropriately supported. The newly appointed care manager was in a process of introducing a staff supervision matrix.
● At our last inspection we identified the registered manager planned to refresh their moving handling train the trainer course. At this inspection we found the registered manager continued to deliver training to staff. We asked to provide us with the evidence of the training, but the provider failed to provide us with it. It meant we could not be reassured the staff received training delivered by a competent and authorised person.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed prior to commencement of the service. This was to ensure people's needs could be met. One relative told us about the review attended with the person and their family to establish the level of care required.
● The assessed needs included people's health and social needs as well as details around people's oral hygiene needs in line with good practice. People's care records stated whether people were independent with their oral hygiene or needed assistance.

Supporting people to eat and drink enough to maintain a balanced diet
● People's care records contained information of people's food likes and dislikes.
● People told us about the support they had around meals if required. One person said, "I tell them what I want to eat, they (staff) know anyway."
● Staff had access to an online training around awareness of people's nutrition needs.

Staff working with other agencies to provide consistent, effective, timely care; supporting people to live healthier lives, access healthcare services and support
● People's care records contained information about people's health needs. The provider would ensure people were signposted to the relevant professionals if needed.
● None of the people we spoke with needed support with contacting doctors for them, but they told us staff would support them with accessing health services if needed. One person said, "They don't need to help me with calling doctors, my friend does it."

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 requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At our last inspection we found the provider had failed to have systems or processes in place to ensure that the quality and safety of the services provided were being monitored effectively and used to drive service improvements. This was a repeated breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found not enough improvement had been made and the provider was still in breach of regulation 17.

- Following our last inspection we agreed with the provider they would be sending us a voluntary, monthly action plan to demonstrate improvements being made. The provider had not sent to us the evidence as agreed, for example, there was a gap of two months where we had received no updates. When we had an update the quality of the evidence sent was not demonstrating sufficiently that progress in relation to improving their governance was being made.
- At this inspection we also found some of the monthly updates we had received were not accurate. For example, the evidence received from the provider for October 2020 stated 'no accidents or incidents' occurred during October. During our inspection we saw a record of an accident to the person using the service that occurred earlier in October. Additionally, the 'manager's review' section of this incident had not been completed and was blank. This meant there was no evidence of any action taken to reduce the re-occurrence.
- The systems in place to monitor the quality of the service and reduce risks were not always effective. For example, the accidents log did not contain details of all accidents that had occurred. The provider's missed visits log did not contain details of all missed visits that had occurred. This meant the systems for identifying, capturing and managing organisational risks and issues were ineffective.
- There was a lack of an embedded system to ensure that staff had the necessary competency checks to deliver care safely, for example staff had not received medicines competency checks. This was not in line with the good practice guidance which stated providers must ensure staff are assessed as competent to give the medicines support being asked of them, including assessment through direct observation.
- The provider had a 'live actions' audit which stated what action was required to be completed, by who and by when. Some of the actions had not been signed off as planned. For example, a staff member was identified as needing moving and handling training and the anticipated completion date was a week prior to our inspection. The action has not been completed as planned and the staff member continued to work without the training being completed.

● The system to ensure that notifiable incidents were reported to Care Quality Commission was not always effective. At this inspection we found an incident occurred in May 2020, where a person threatened to harm themselves and the staff member. We had not been notified about this occurrence as required. Additionally, since our last inspection we received three notifications that did not meet the threshold of a notifiable incident which showed the poor understanding of the provider around their regulatory responsibilities.
● The provider had not ensured their quality assurance systems remained effective. The provider's quality assurance policy said, "The registered manager or delegated other will undertake monthly quality audits and reviews of the service as dictated by the quality framework". These were to include a number of topic areas surrounding the service delivery and the results should be 'analysed and used to develop action plans to enable achievement of improvement'. There was no evidence of any of these regular monthly audits taking place. This meant the provider was not operating accordingly to their own quality assurance policy.
● There was a care plan audit completed the month prior to our inspection and it had identified a series of concerns. We found the audits did not include areas we identified as needing improvement, for example, missing information about people's medicines.
●The repeated concerns we found demonstrated the provider did not ensure their quality assurance systems remained effective. The provider was found at breach of regulation around good governance at the last two inspections; in January 2019 and January 2020.

The above was a repeated breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people.
● Since our last inspection we had been receiving mixed messages about the leadership at the service. The provider told us in July 2020 they had hired a Quality and Compliance Manager however, this never materialised. We had also been informed the registered manager resigned in September, but the registered manager was still registered at the time of this inspection. Recently one of the staff members had been appointed as a Care Manager and was in a process of registering with the CQC as a registered manager. This meant support from managers was not always consistent and managers did not lead effectively.
● The provider informed us in their Provider Information Return (PIR) submitted to us in March 2020 that this was the year when they were to achieve a "Good" rating. The findings of this inspections demonstrate this had not been achieved.
● Management did not understand the principles of good quality assurance and the service lacked drivers for improvement.
● The feedback from people about the care they had was positive. Comments included, "They do go above and beyond. More than happy with them" and "Can't think of any concerns."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● A satisfaction survey had been recently carried out. Only nine people returned the survey and their comments were mostly positive. Some areas had been identified as needing improvement, for example, staff to have sufficient skills to support people.
● The provider informed us in their PIR sent to us earlier this year, they were going to change their 'review frequency to three months instead of six, every other review will be in person and every other will be over the phone'. The evidence to show timely reviews took place were not always available.
● The management team were in a process of carrying out a staff survey. The survey questionnaires had been given out to staff and the responses will soon be collated and analysed.

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. Continuous learning and improving care.

- The management team were aware of their responsibility around the duty of candour.
- People and relatives commented there was a good communication maintained. One relative said, "(They) contact me if needed."

Working in partnership with others

- The provider worked with various social and health professionals as needed.
- We were notified by the local authority that following a safety concern a decision had been made to cease the partnership working with the provider.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure effective quality assurance systems and failed to ensure their governance remained effective. That was a breach of Regulation 17 (1)(2)(a)(b)(c).

The enforcement action we took:

We issued a Warning Notice.