Home Angels Healthcare Services Ltd

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Inspection report

Suite 16, Innovation House
Molly Millars Close
Wokingham
Berkshire
RG41 2RX

Tel: 02045180064
Website: www.homeangelscare.com

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Home Angels Healthcare Service Ltd is a domiciliary care agency providing personal care to people. The service provides support to children, younger adults, older people and people who may have dementia, a physical disability or sensory impairment. At the time of our inspection there were 13 people using the service.

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
People's risk assessments were not always person centred and did not include information for staff on how to safely mobilise people. Although incidents had been identified, lessons learned were not always documented.

Although we recognised some changes implemented by the new management team and additional improvements were planned, we found the provider's governance required further improvement. We took this into consideration when making our judgement to ensure the most proportionate regulatory response to the concerns identified. Notifications had not always been sent to CQC when required.

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 4 May 2023). The service remains rated requires improvement. This service has been rated requires improvement for the last 5 consecutive inspections. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We undertook this targeted inspection to check whether the Warning Notice we previously served in relation to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. The overall rating for the service has not changed following this targeted inspection, and remains requires improvement. We use targeted inspections to follow up on Warning Notices or to check concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

Enforcement and recommendation
We have identified breaches in relation to safe care and treatment, notification of incidents to CQC and

good governance at this inspection.

We have recommended the provider reviews training in relation to learning disability and autism.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Is the service effective?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Home Angels Healthcare Services Ltd

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by 2 inspectors.

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

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was not a registered manager in post.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because the service is small and people are often out and we wanted to be sure there would be people at home to speak with us.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information

providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We spoke to the local authority to gain feedback regarding the service. We reviewed information we held about the service since the last inspection. We also looked at online reviews regarding the service. We used all this information to plan our inspection.

During the inspection
We spoke to 4 staff including the care manager, compliance officer, director and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records including 4 people's care plans and risk assessments and incident and accident records. We also reviewed the service's governance systems, including audits and feedback from people and relatives.

Inspected but not rated

Is the service safe?

Our findings

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

At our last inspection this key question was rated requires improvement. We have not changed the rating as we have not looked at all of the safe key question at this inspection.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served. We will assess the whole key question at the next comprehensive inspection of the service.

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

At our last inspection, the registered person had failed to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● The provider had risk assessments in place for identified risks such as moving and handling, catheter care, personal care and wheelchair usage. However, they were not always person centred and did not always include information for staff on how to mitigate risks to people.
● 4 people's risk assessments were reviewed in relation to moving and handling. We found 2 had identical wording, although risks and needs of people were different.
● All 4 moving and handling risk assessments did not explain how to support people individually to meet their needs. They included information such as, "Staff to pay particular attention to: Reduce loads e.g., organise shopping bags to reduce weights carried between sites. Use a suitable bag … Correct techniques applied for lifting equipment in and out of car". The service did not ensure people's risk assessments documented actions to ensure staff were aware of how to mitigate the risk and to avoid injury.
● Information within the care plan was inaccurate and did not meet the needs of the person.
1 person's care plan stated they were bed bound however, within their personal care risk assessment it stated, "After Personal care staff to assist [person] to sit on the riser-recliner chair and make [person] comfortable".
● Not all incidents and accidents had been recorded effectively in order to identify areas of improvement within the service. This was raised to the nominated individual and care manager who confirmed an incident and accident record matrix was not in place at the time if this inspection, however they advised this will be rectified.

The provider had failed to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a continued breach of regulation 12 (1)(2)(a)(b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspected but not rated

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 our last inspection this key question was rated requires improvement. We have not changed the rating as we have not looked at all of the effective key question at this inspection.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served. We will assess the whole key question at the next comprehensive inspection of the service.

Staff support: induction, training, skills and experience

At our last inspection, we found the provider had not followed recruitment procedures or obtained the information required by the regulations to ensure the suitability of all staff employed. This was a breach of regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

- All new staff completed an induction which included shadowing senior staff and completing all practical training required, including the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
- We found staff received additional training in specialist areas, such as catheter care
- In July 2022, a requirement under the Health and Care Act 2022 for all CQC registered service providers to ensure their employees receive learning disability and autism training appropriate to their role. This is to ensure the workforce have the right skills and knowledge to provide safe, compassionate and informed care to autistic people and people with a learning disability. The Oliver McGowan Mandatory Training on Learning Disability and Autism Training requires staff to complete the e-learning launched on 1 November 2022, and the corresponding standardised online interactive session or face to face training which will commence in early 2023.
- At the time of the inspection, staff had not received this training. This was raised with the nominated individual who agreed this would be reviewed and implemented.

We recommend the provider reviews current requirements in relation to learning disability and autism training.

Inspected but not rated

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection this key question was rated requires improvement. We have not changed the rating as we have not looked at all of the well-led key question at this inspection.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served. We will assess the whole key question at the next comprehensive inspection of the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At the last inspection, the registered person had not operated an effective system to consistently enable them to assess, monitor and improve the quality and safety of the service provided. This was a continued breach of Regulation 17(1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● During this inspection, we found the provider continued to be in breach of regulations 12 and 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and regulation 18 of the Care Quality Commission (Registration) Regulations 2009, all of which are continued breaches. The providers governance systems had failed to identify the evidence found during the inspection of the continued breaches in order to continue to improve the service.
● The provider did not have effective systems in place to ensure information documented within people's risk assessments was accurate, person centred and provided staff with information to mitigate risks to people.
● Although feedback had been requested by people and relatives, there is no evidence the feedback had been analysed to identify areas of improvement for the service or what was working well.
● At the last inspection, the nominated individual advised they were planning to develop a system to monitor themes and trends to improve the service. However, at this inspection, this had still not been implemented.
● It was confirmed by the care manager and Nominated Individual that an incident and accident matrix was not in place at the time of inspection, and some incidents had been recorded on the services compliments and complaints log.
● 1 incident had not been recorded on any log and there was no documentation of areas of learning and improvement.
● At the time of the inspection, there was no registered manager in place. The previous manager had de-registered in April 2023 and the provider was in the process of finding a replacement.

The registered person had not operated an effective system to consistently enable them to assess, monitor and improve the quality and safety of the service provided. This was a continued breach of Regulation 17(1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider sent evidence of an incident and accident matrix to the inspector to review.

At the last inspection, the provider failed to notify the Commission of notifiable events without delay. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● Of the 2 incidents that had occurred since the last inspection, 1 was required to be sent to CQC as a notifiable incident. The provider had not notified the Commission of the notifiable event.
● Following the de-registration of the previous registered manager, the provider must submit a notification to the Commission to explain who will be managing the day-to-day running of the service. Although the Nominated Individual evidenced they had attempted to send in the notification, it did not specify who would be managing the service in the absence of a registered manager.

The provider failed to notify the Commission of notifiable events without delay. This was a continued breach of Regulation 18(1) of the Care Quality Commission (Registration) Regulations 2009.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents How the regulation was not being met: The provider failed to notify the Commission of notifiable events without delay. Regulation 18(1)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: The provider had failed to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. Regulation 12 (1)(2)(a)(b)