Angel Solutions (UK) Ltd

Angel Solutions Community Care

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Angel Solutions Community Care is a domiciliary care agency providing personal care to eight people at the time of the inspection.

People's experience of using this service and what we found
At our last inspection we found the registered manager had worked hard to turn the service around following an inadequate rating, to ensure people received safe care. Shortly after the inspection, the registered manager resigned their position and the service was managed by a former registered manager from another branch of the organisation.

During this period there was a marked decline in the quality of care. The people we spoke to were overwhelmingly negative about the support they received. One person said, "I do not feel they are kind and caring but I am afraid to make a fuss." We were concerned the provider had not acted promptly to prevent the deterioration in care.

Staff did not have access to care plans that sufficiently detailed how they should manage peoples individual risks. Some of the systems in place at the last inspection, such as complaints management, had been poorly maintained. Regular quality checks took place. However, continued negative feedback from people indicated actions taken as a result of feedback had not resulted in improved care.

People raised concerns around staff arriving on time and staying for the allocated time. Action had not been taken by the provider to address this. The new manager told us they were setting up a new system to ensure staff visited at the agreed times. This was not yet in place at the time of inspection.

People told us they received their medicines as required. However, we were concerned poor timekeeping meant they did not always receive medicines at the right time.

There were systems in place to support people to have choice and control of their lives, such as regular reviews of care. However, because the systems were not working well, support was not always provided in people's best interests. Further improvements were needed to ensure people had greater control over the service their received.

The provider had processes in place to prevent the spread of infection. People told us they felt staff took the necessary precautions to minimise the spread of COVID-19.

A few weeks before our recent inspection a new manager was appointed and had started to address poor practice. However, further time was needed to ensure these positive changes were fully embedded and sustained.

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 requires improvement (published 7 January 2020). The service remains rated requires improvement. This service has been rated requires improvement or inadequate over the last three consecutive inspections.

Why we inspected
The inspection was prompted in part because we had received serious concerns about the provider's quality of care and oversight at their other service. A decision was made for us to inspect and examine the risks at the service in Southend-on-Sea. 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. Although we found concerns in other areas, these related specifically to the lack of effective management. We have therefore recorded these concerns under the well-led section of the report. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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

Enforcement
We found the quality of care people received had deteriorated since our last inspection. At this inspection we have identified three breaches in relation to the provider's failure to ensure people received safe care and care which was dignified and respectful. The rating for well-led has deteriorated to inadequate.

At a previous inspection we had placed conditions on the service. We did not find there had been enough improvement to remove all these conditions. We therefore required the provider to continue sending us monthly information reports about the actions they were taking at the service. We also kept a restriction on the service providing personal care to any new people without the written permission from the Care Quality Commission.

Please see the action we have told the provider to take at the end of this report.

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 continue to monitor progress and will return to visit in line with 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? The service was not always safe	**Requires Improvement**
Is the service well-led? The service was not always well led.	**Inadequate**

Angel Solutions Community Care

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
The inspection team consisted of four inspectors. Two inspectors visited the office and a further two inspectors spoke with people, families and staff.

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 the provider is legally responsible for how the service is run and for the quality and safety of the care provided. The previous registered manager had left and a new manager had been appointed who had applied to be registered with the CQC.

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 that the provider or manager would be in the office to support the inspection.

Inspection activity started on 19 October 2020 and ended on 29 October 2020. We visited the office location on 20 October 2020.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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.

We used all of this information to plan our inspection.

During the inspection
We spoke on the phone with four people who used the service and three relatives about their experience of the care provided. We rang four members of staff. At the office visit we met with the new manager and a provider representative who was assisting with the running of the service.

We reviewed a range of records, including four people's care records and medication records. We looked at records relating to the management of the service, including two staff files and quality audits.

After the inspection
Due to COVID-19 we tried to minimise the time we spent at the office. After the inspection we rang the manager to provide feedback and request additional information. We spoke with the local authority to share feedback about the service and provide information regarding a specific safeguarding concern.

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 now 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.

Assessing risk, safety monitoring and management
• Staff had access to care plans that provided them with information about people's needs and preferences. However, some plans missed out key information and had not been updated following changes in people's circumstances. One care plan did not give staff clear advice on how to support a person who refused personal care and food due to their dementia. Quality checks were not effective in monitoring the support the person received and therefore minimising risk to their safety.
• Another person had raised concerns about having unsafe care. This concern was confirmed by a health professional. Whilst the person and a professional working with them told us the care had improved, the care plan had not been updated. Consequently, staff did not have access to guidance on how to safely care for the person.
• Whilst we found some care plans lacked important information, they did contain varied advice about keeping people safe, such as how to work with district nurses to help prevent pressure sores.
• The impact of a lack of detailed care plans was minimised due to the stable staff group and because we had placed limits on the expansion of the service.
• The new manager described their plans to improve care planning, including contacting professionals to ensure information about people was up-to-date and accurate. We discussed the need to ensure the improvements to care planning were in place prior to supporting new people.

The provider had failed to ensure staff had sufficiently detailed care plans to mitigate risk of unsafe care and treatment. 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
• A person had disclosed during quality checks that a member of staff had not supported them in a dignified manner. The provider met with staff as a result, however we found the actions taken to protect people from the risk of abuse had not been effective. This is discussed further in the well-led section of the report.
• The provider worked with the local authority to resolve and support people following serious concerns, however, they failed to report all safeguarding concerns to the Commission. We discussed this with the new manager and shared guidance to ensure they knew when to let us know about safeguarding concerns.

Staffing and recruitment
• People had raised concerns about staff arriving late and not staying the allocated time. At our last

inspection, key senior staff had been responsible for checking staff were on time. At this inspection, we found punctuality had deteriorated. The provider had discussed timekeeping with staff; however, this action had not resulted in improvements.
• New staff had not received practical manual handling training from a suitably qualified trainer. The people currently being supported did not require significant assistance to move safely so the impact was minimal. However, after our feedback the new manager arranged face to face training and competency checks from an external provider to ensure new staff had the necessary skills to provided safe support.
• New staff detailed the training they had received when they had started at the service. Since the COVID-19 pandemic all training was online, complemented by shadowing and competency checks by more experienced staff. This lack of practical training had not had significant impact on the service as the people being supported were known to staff.
• The new manager had purchased a new scanning system to monitor visit times. Although this was not yet in place, this demonstrated effective and prompt action to ensure people would receive the agreed level of care.
• There was an established care team and set rotas provided continuity for people receiving care.
• Recruitment checks had been completed on prospective employees to ensure staff were suitable for the caring role.

Using medicines safely; Learning lessons when things go wrong
• People told us they received support from staff to take their medicines, however concerns around staff punctuality meant we could not be assured the support was provided at the correct times.
• Staff described how they supported people with their medicine, and demonstrated they knew how to ensure people received their medicines safely.
• The provider had recently implemented changes in medication practice around prompting people with their medicines. They told us they had not referred to any nationally recognised guidance when making these changes. We signposted them to the NICE guidelines [NG67], "Managing medicines for adults receiving social care in the community."
• We found examples where effective action had been taken following medicine errors which resulted in people receiving safer care. In one instance a care coordinator had taken action which represented good practice. They had communicated openly with the person and reviewed staff competency.

Preventing and controlling infection
• The new manager had attended specialist training on infection control and was working with staff to ensure they provided safe care.
• Staff were using PPE effectively and safely to help minimise the risk of infection. All the people we spoke with told us staff used PPE as required. A person told us, "They always wear gloves, mask and aprons I have no concerns about not being safe."
• The provider's infection prevention and control policy was up to date.

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. 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

• The registered manager had left the service shortly after our previous inspection. The service had been without a registered manager since January 2020 and the quality of care provided in this period had deteriorated.

• The provider had not maintained the complaints log for the period of time without a registered manager or taken appropriate action when concerns were raised. Complaints included negative staff attitude and poor timekeeping.

• The provider continued to carry out quality checks including gathering people's views and carrying out spot checks on staff. A member of staff told us, "They do checks on us which are not announced, like if we are on time, wear our uniform and PPE." However, when the checks raised concerns, the provider failed to use the information to make positive changes.

• The provider showed us written records of actions they had taken to address the feedback around poor care. However, feedback from people and our discussions with the provider demonstrated that these actions had not always been successful.

• Previously, we had placed conditions on the provider to support them to improve the service. However, the provider had not prevented a marked deterioration in the quality of care following the departure of the previous registered manager, resulting in breaches of the Health and Social Care Act 2008.

• We had taken legal action against the provider at their other service, in Croydon. We were concerned the provider had failed to learn lessons from this experience to prevent a decline in the safety and quality of care at their service in Southend-on-Sea.

The provider had failed to take effective action to ensure people received good quality, safe care. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The new manager had only been in place for a few weeks at the time of our inspection and any changes were still being implemented.

• They told us they were enthusiastic about turning the service round, for example introducing the new system to check visit times. They said, "I met with staff to tell them about the new scanning system and told if they weren't on time, they would lose pay."

• Staff gave us positive feedback about the new manager, "They seem a nice person. The manager had a meeting with me asking about things I would like to change. There are a few things they want to change which seems to be the right path."
• This was the manager's first role as manager of a service and so they lacked experience in some key areas of the role. The manager told us they had access to an external consultant for advice. However, this consultant had been in place for some time and the provider had not used this resource to prevent deterioration of rating and breaches of regulation.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• Whilst care staff spoke about people in a caring way, feedback from people and families about staff attitudes was overwhelmingly negative. There was some positive feedback about individual members of staff, however the culture was not consistently person-centred and caring. A person told us, "I don't feel like they put me first. I feel they do things that are easier for them. They do not follow the care plan; they do things how they want it done."
• Many of the concerns people raised reflected poor patterns of care which had not been acted on effectively by the provider. For example, some staff talked to each other rather than the person during visits and did not ensure people had privacy during personal care. We found instances where people had told the provider about concerns with staff attitudes months ago and when we rang the person, we were told there had been no change.

The provider had failed to ensure people were treated with dignity and respect. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following our inspection the new manager sent us a revised action plan. This gave us clearer information of what they were doing to make things better. For example, when they had met with staff to discuss concerns about dignity and respect

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
• We examined an internal investigation about two members of staff who had left the service following a complaint. The provider told us they could not remember the events which followed the investigation and the actual reason for the departure of the staff. They told us they could not find the staff files. We found we were not able to have an open discussion about the incident.
• The provider had not developed positive relationships with key local organisations, for example, contact with the local authority mainly involved reacting to requests for information or concerns. The new manager worked openly with us during the inspection. They spoke positively about developing contacts and networks locally which would promote best practice and support improvements at the service.
• Following our inspection, the new manager sent a letter of apology to a person who had not received dignified care, detailing the actions they had taken to resolve the concern. This represented an open approach and an awareness of the services duty of candour.
• We found examples where senior staff had worked well with individual professionals following concerns. A social care professionals said, "When I discussed the above concerns with senior staff, these were acted on appropriately."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People told us senior staff spoke to them frequently to find out about their views, however this did not

always result in improvements. One person said, "I am sick of talking to people and telling them I am unhappy, and nothing gets done about it." We discussed with the manager the need to ensure people were involved in a meaningful, proportionate manner.

• Staff told us the provider had communicated well with them while there was no manager in place. However, we were not assured the communication had been effective due to the dip in the quality of care and concerns raised by people during this period.

• The new manager's communication with staff following our inspection demonstrated a positive commitment to involve staff in improvements at the service.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure people were treated with dignity and respect.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure staff had sufficiently detailed care plans to mitigate risk of unsafe care and treatment. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to take effective action to ensure people received good quality, safe care