

Home Angels Healthcare Services Ltd

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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?

Requires Improvement ●

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 14 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 up to date or included enough information in order to keep people safe and mitigate those risks. The visits were scheduled using an online system and this was overseen by the registered manager. People were not always happy with the way staff provided care and support. We have made a recommendation regarding the providers recruitment records of new staff.

Staff had received training in topics the registered manager considered mandatory. However, the training was not in line with best practice guidance. The registered person had not followed up on the recommendation made at the last inspection relating to referring to best practice guidance regarding staff training. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The provider did not ensure systems were in place to oversee the service and ensure compliance with the fundamental standards. They did not ensure the Care Quality Commission (CQC) was informed of notifiable incidents in a timely manner.

The staff team followed procedures and practices to control the spread of infection using personal protective equipment.

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 January 2022). The service remains rated requires improvement. This service has been rated requires improvement for the last 4 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.

At our last inspection we recommended that the provider ensures staff training is up to date and seek advice

and guidance to ensure training is in line with best practice. At this inspection we found the provider had not made enough improvement.

Why we inspected

We carried out an announced focused inspection of this service on 1 December 2021. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve recruitment records and good governance of the service.

We undertook this focused inspection to check they had followed their action plan 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.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

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

Enforcement and Recommendations

We have identified breaches in relation to risk assessments, staff training and notifications of incidents to CQC.

We have made a recommendation regarding recruitment records.

We issued a Warning Notice to the provider regarding relating to good governance. The provider is working with us to address the issues raised.

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?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

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 and 1 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

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 a registered manager in post.

Notice of inspection

This inspection was announced.

We gave the service 24 hours' notice of the inspection. This was because it is a small service and we needed

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

What we did before the inspection

We reviewed 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 with 6 members of staff including the administration manager, office staff, carers and the 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. This included 4 people's care records and multiple medicines records. We looked at 4 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were also reviewed. We spoke with 7 relatives and 2 people who use the service.

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 we rated this key question requires improvement. The rating for this key question has remained requires improvement. 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; Learning lessons when things go wrong

- The registered manager carried out risk assessments in relation to aspects of care such as nutrition, pressure prevention, mobility, oral care and personal care.
- During the inspection, we identified risk assessments were not always updated or amended in line with changes to a person's health or social care needs. For example, one person had been in hospital and returned home in January 2023. On their return, their needs had changed significantly. The risk assessments within the care plan provided by the nominated individual and reviewed during the inspection were not updated to reflect their current needs so staff were aware of how to mitigate any risks.
- Following the inspection, the provider notified the inspector a more up to date care plan with the updated risk assessments was available and this was provided.
- Another person was not able to have anything orally. However, their risk assessment said to offer drinks when taking medicines. This put the person at risk of choking.
- The provider had a system in place to record incidents, accidents and concerns reported to them.
- The registered manager did not ensure the system in place was followed and appropriate records kept when incidents or accidents occurred. For example, where a person was found to have a deep tissue injury, there were no learning points documented to support staff in how to mitigate the risk of recurrence and support healing of the injury.
- The registered manager did not ensure there was consistent further review and learning from those events to reduce the risk of recurrence. Where staff had recorded actions needed following an incident or accident to prevent recurrence, learning points had not always been documented.

The registered manager 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 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection, the provider reviewed and updated the information documented with people's care plans to provide further clarity to staff in order to keep people safe.

Staffing and recruitment

At our last inspection, 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 19 (1) 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 19.

- The service did not ensure all recruitment records contained evidence of conduct from previous roles within health and social care.
- Of the 4 recruitment files we reviewed, 1 did not have the required recruitment information. Missing information included evidence from previous employment regarding staff's conduct and verifying reasons for leaving.
- Failing to obtain all required recruitment information could place people at risk of receiving care from unsuitable staff.

We recommend the provider reviews all staff recruitment records to ensure all relevant checks and information is recorded.

- The provider completed Disclosure and Barring Service (DBS) checks for all new staff. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
- Some people and relatives told us staff could be late to visits and there was not always enough staff. They said, "They never seem to have enough staff. There is a high turnover of staff", "Timing is a problem. Arrival times are not consistent. The last call for bedtime can be too early and the morning visit is often late. It has been as late as 11am and the evening visit has been as early as 5:30pm". Other relatives told us timings had improved in recent times, "They vary a bit on arrival times but not too badly", "They generally arrive on time but can be later if they have been held up with a previous call. We have no problem with that. We do feel safe with the carers who come to see us".
- Staff told us there had been concerns with the travel time between calls which could cause them to be late in the past, however, they agreed this was improving. They said, "Rotas in the past did not have enough travel time due to lack of staff especially at weekends. Now [a new computer programme] is helping us."

Systems and processes to safeguard people from the risk of abuse

- We received mixed feedback from people and relatives when we asked if they felt safe, "[Person] is not safe with the carers who come...They are people we don't know. A lot of them fall asleep when they should be keeping an eye on [person]. The staff who come regularly recently are OK." Another relative also said they did not feel their loved one was safe with the care staff. However, other people told us, "I generally feel safe with my carers", "We do feel safe with the carers who come to visit us."
- Staff spoken to confirmed they had received safeguarding training and were able to state what action they would take in response to witnessing abuse, including contacting the local authority safeguarding team.

Using medicines safely

- Medicines omissions were not always addressed. There was a process for auditing medicine administration record (MAR) charts. We reviewed MAR charts and found a number of gaps. The registered manager did not ensure these omissions were reviewed appropriately to identify if it was an issue with staff recording, administration or both.
- People had clear and detailed protocols for 'as required' medicine so the staff could support them in a timely way.
- All staff who gave medicines to people had received training in medicines management and an annual competency check was completed by a senior member of staff.

Preventing and controlling infection

- Staff were trained in infection control and followed the provider's policies and procedures in this area. People and relatives confirmed this and said staff wore the protective equipment while supporting them when required.

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 we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

At our last inspection, we recommended the provider take action to ensure staff training was up to date and seek advice and guidance to ensure training was in line with best practice. The provider had not made enough improvements.

- Not all staff had received the training required to meet the needs of people with complex health requirements. For example, one person needed support with breathing, but the registered manager did not ensure staff received specific training to understand the condition and how to manage related risks.
- There was evidence some staff had not received fire training annually as recommended and in line with best practice.
- Staff were not up to date with required mandatory training in line with best practice. For example, 3 staff had not received training in relation to moving and handling within the last year and 2 staff were overdue safeguarding adults training.

The provider had not ensured staff were suitably qualified, competent and experienced to carry out their roles effectively. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- New staff attended an induction day and were supported to complete 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.
- Senior staff carried out spot checks, observations and competency assessments to ensure staff were meeting the needs of people.

Ensuring consent to care and treatment in line with law and guidance

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 MCA 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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

- People's capacity was taken into consideration when care planning.
- A completed mental capacity assessment for another person stated they had capacity to make all decisions. One person's physical health risk assessment stated that when the person is unwell, staff should consult their next of kin to make decisions.
- Staff told us they had completed training in the Mental Capacity Act (2005) and this was confirmed by the providers training matrix. However, this was completed on a 3 yearly basis rather than annually and in line with best practice.

Supporting people to eat and drink enough to maintain a balanced diet

- Where appropriate, staff supported people with their nutritional intake. Nutritional risk assessments were carried out and care plans incorporated advice from dieticians, for example, in relation to fortifying foods to support a person's nutritional intake.
- Staff supported people to eat and drink. This included for people with specific needs in relation to providing a soft diet and support while eating due to the risk of choking.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- Staff worked with external professionals to meet people's care needs. This included incorporating external advice within care planning.
- Staff understood who to contact for support to provide effective and timely care. This included contacting GPs and specialist services such as an emergency palliative care line for people who are at the end of life.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Care plans contained clear information on how people should be supported in order to meet people's needs safely and effectively. Information had been sought from the person, their relatives and other professionals involved in their care.
- However, people told us their care plans were not always accurate. For example, one person's care plan stated, "Overnight requires oxygen monitored." However, it was confirmed by the person and their relative this is not accurate. The nominated individual stated people's care plans are reviewed every 3 months however this had not been identified in the most recent audit. This has been dealt with in the well-led domain.
- Other people and relatives spoke positively of the service, "The one carer who visits on a regular basis is very good", "They always treat [person] with respect".
- Daily notes of people's care recorded if people felt low in mood, stressed or anxious, however, did not record people's emotional and psychological welfare daily.

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 we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

At our last inspection, the registered person had not operated an effective system consistently to enable them to assess, monitor and improve the quality and safety of the service provided. The registered person had not established or used an effective system to enable them to ensure compliance with their legal obligations and the regulations. This was a continued breach of Regulation 17 (Good governance) 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.

- At this inspection, we found the provider was in breach of 4 regulations.
- Regular audits had taken place however; the registered manager did not ensure the audits were robust and had failed to identify the concerns we found during our inspection such as notifications not sent to CQC, gaps in a medicine administration record and missing information within a staff recruitment record.
- There was no documentation of themes and trends that had been identified with the service's incidents and accidents. The nominated individual advised they are planning to develop a system to monitor themes and trends in order to improve the service however, it was not yet in place.
- Following the last inspection, the provider completed an action plan requested by CQC to evidence how they will improve the service. However, we found during this inspection, the provider did not use their quality assurance systems to ensure there was a consistent and comprehensive overview of the service, to ensure people received high quality care and support.

The registered person had not operated an effective system consistently to 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.

- During this inspection, we found the provider had failed to ensure CQC was consistently notified of reportable events without delay such as allegations of abuse.
- This meant we could not check that appropriate action had been taken to ensure people were safe at that time.

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- We received mixed feedback from people and relatives regarding the service. One relative told us "The quality of support I get is very poor and I am very unhappy with the service we get." However, others told us, "I would say it is reasonable managed... I would recommend the service."
- Team meeting minutes recorded identified that staff had the opportunity to raise concerns.
- Staff told us they felt listened to by the management team.
- The management team were welcoming to the inspection team and demonstrated an open and transparent approach through acknowledging continued improvements to the service were required. Staff agreed the management team were working to promote a positive culture at the service.

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

- There were no serious injuries reported as notifiable incidents in the last 12 months. Regulation 20 sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology.
- The provider had an up to date duty of candour policy in place and the nominated individual was aware of their responsibilities of being open, honest and transparent when something goes wrong.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People and their relatives gave us mixed feedback about their involvement. One comment included, "I have complained many times, but nothing happens". Another person told us, "It is difficult to get hold of anybody in the office and it certainly needs organizing better."
- Evidence of annual appraisals and regular supervisions with staff was seen and this was confirmed by staff. This meant staff had an opportunity to discuss their work life and career objectives with their relevant line managers.
- Staff told us they knew how to raise concerns and felt they would be confident enough to do so with the new management team.

Working in partnership with others

- The provider worked with a number of health and social professionals, this included the local commissioners and health professionals such as the local GP surgeries.

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	<p>Regulation 18 Registration Regulations 2009 Notifications of other incidents</p> <p>How the regulation was not being met:</p> <p>The provider failed to notify the Commission of notifiable events without delay.</p> <p>Regulation 18 (1)</p>
Personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>How the regulation was not being met:</p> <p>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.</p> <p>Regulation 12 (1)(2)(a)(b)</p>
Personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>How the regulation was not being met:</p> <p>The provider had not ensured staff were suitably qualified, competent and experienced to carry out their roles effectively.</p> <p>Regulation 18 (1)(2)(a)(b)</p>

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	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>How the regulation was not being met:</p> <p>The registered person had not operated an effective system consistently to enable them to assess, monitor and improve the quality and safety of the service provided.</p> <p>Regulation 17 (1)(2)(a)(b)(c)(d)(e)</p>

The enforcement action we took:

Warning Notice