Angel Solutions (UK) Ltd

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Inspection report

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Date of inspection visit:
15 July 2019

Date of publication:
21 August 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Angel Solutions (UK) Ltd is a domiciliary care agency providing personal care to eight people at the time of the inspection. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
Our inspection identified a number of concerns at the service. The provider sent staff into people's homes before confirming they were safe and suitable to provide care and support. This was because recruitment processes were inadequate. Staff job applications were not fully completed. References from previous employers were not asked for and when staff had a criminal record the provider did not make sure they were safe to care for people

The provider was not transparent when dealing with other agencies which were concerned about people's safety. For example, the provider destroyed all records relating to a person who had died and the staff who supported them. This was in violation of the provider's own information retention policy. The provider refused to share information with a local authority which had concerns about people's safety.

Risk assessments and plans for the management of behaviours which may challenge were inadequate. This meant that staff had no guidance on the actions they should take when people presented with behavioural support needs. This placed people and staff at risk of harm.

Governance of the service continued to be poor. Quality assurance processes were not robust. They failed to identify and address the failings we found during this inspection. No improvements had been made to the providers inadequate recruitment or risk assessing processes since our last inspection. Management records contained inaccurate information such as the wrong rota details and many of the documents we requested had been shredded or could not be found by the registered manager and administrator.

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 Inadequate (published 30 April 2019) and there were multiple breaches of regulation. 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 improvements had not been made and the provider remained in breach of regulations.

Why we inspected
This focused inspection was prompted in part due to concerns received from a Coroner and a health and social care professional following an inquest into the death of a person who had received care from Angel

Solutions (UK) Ltd. The concerns included inadequate care, inadequate records and a failure to be open and honest. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-Led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.
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 has not changed from inadequate. 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 Angel Solutions (UK) Ltd on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to Safe Care and Treatment, Good Governance and Fit and Proper Person's Employed. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Angel Solutions (UK) 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 two 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.

Notice of inspection
This inspection was unannounced.

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 with the administrator and the registered manager. We reviewed a range of records. This included four people's care records and medicines records. We looked at four staff files in relation to recruitment. We also checked the provider's quality assurance processes and a variety of records relating to the management of the service.

After the inspection
We spoke with two people and four health and social care professionals. We continued to seek clarification from the provider to validate evidence found.

Inadequate

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 Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment
At our last inspection the provider had failed to operate effective recruitment procedures. This was a breach of regulation 19 (Fit and proper persons employed) 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 19.

● The provider placed people at risk by recruiting staff without making sure they were safe to provide care to people. For example, one member of staff had a conviction for violence. There were no risk assessments in place for this staff member and the provider failed to obtain two satisfactory references for them. This meant the provider did not know how they performed in previous roles or why their employment ended. In addition, the provider failed to establish and record the reason for gaps in this staff members employment history.
● Staff files contained inaccuracies and inconsistencies. For example, two staff members had references from the same employer despite neither staff having worked for the employer or listed them as a referee. Neither staff listed this employer in the employment histories and both staff stated in their applications that they were working elsewhere during the period covered in these references. The registered manager and administrator said they did not know how this anomaly had occurred.
● The provider sent staff into people's homes before establishing they were suitable. We found that one member of staff had received a written warning from the provider three days before the start of our inspection. We checked this staff members file to see how the provider had assured themselves of this staff member's safety and suitability at the time of recruitment. We found this member of staff had been employed without any employment references or character references. This meant people continued to be exposed to potentially unsafe staff.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) 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

● People's risks were not always appropriately assessed. The provider inadequately assessed the risks for a person who presented with behavioural support needs and care records continued to provide staff with inadequate guidance to manage them. For example, staff were not provided with person centred strategies to deescalate the person's anxieties or specific interventions to keep them safe. Instead the only guidance noted in care plans was to "Remain patient" and, "Don't lash out."
● Concerningly, we also found that the person who presented with behavioural needs was supported in their home by the member of staff referred to above who had a conviction for violence, unexplained gaps in their employment history and no appropriate references. This meant the provider placed an unsuitable member of staff in the home of a person with behaviours which may challenge without appropriate guidance in care records to manage situations safely.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● People did not always feel safe. One person told us, "I'm frightened because I can't do things for myself and [staff name] turns up late and leaves early. That's no good. [Separate staff name] is good though."
● The provider was not always cooperative or transparent in situations where things had gone wrong. For example, during an inquest into the death of a person who had received care and support from Angel Solutions (UK) Ltd the provider failed to share information appropriately. One health care professional told us that one staff member's, "Personnel file had been shredded and [care]notes had gone missing." Referring to the inquest hearing the healthcare professional said of the provider that their "Recall was poor and evasive." This included being unable to remember the surname of the member staff who had been the main carer for the person who had died.
● As part of one local authority's attempts to safeguard people who may be at risk from Angel Solutions (UK) Ltd, health and social care professionals requested the details of all the people receiving care and support from the provider. The provider refused to share this information stating that it was confidential. This prevented the local authority from carrying out its statutory function to keep people safe.
● Before the inspection we wrote to the provider and requested information about the action they had taken since this death to reduce the risk of a similar incident occurring and any additional action they intended to take in response to concerns raised by a Coroner. The provider did not send us this information. Instead they told us that the eight days we had given them to respond was not enough. By failing to respond to our request in a timely manner the provider hindered our ability to assess whether people were safe.
● At the inspection we attempted to check care records of the person who died and the files of staff who had been in their home. None of the staff files were available and the relevant rotas which would have identified staff had been destroyed. The registered manager and administrator informed us that none of the staff were still working for the provider and their staff files were shredded when they left. Shredded staff files including all recruitment, training and supervision records. When we informed the provider that this action was against their own data retention policy we were told all the records were shredded accidently.

The provider failed to act in an open and transparent way when things had gone wrong. This is a breach of regulation 20 (Duty of Candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● People received their medicines in line with their care plans and prescriber's instructions. Medicines records were signed appropriately.
● One person told us, "The carers give me my medicine like they're supposed to."

Preventing and controlling infection

● To prevent the spread or risk of infection staff wore personal protective equipment such as aprons and gloves when providing person care.

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 Inadequate. At this inspection this key question remained the same. 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.

At our last inspection the provider had failed to assess, monitor and improve the quality and safety of the service. This was a repeat breach of Regulation 17 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider's quality assurance processes failed to improve the quality of the service. One health and social care professional told us they had concerns regarding the governance of the service.
- Where shortfalls had been identified the provider failed to take action. For example, at our March 2019 inspection we found an inadequate risk assessment and risk management plan to support the needs of a person with behaviours which could challenge. At this inspection, four months later, no improvements had been made to these care records. The provider had failed to review and update this person's care records since our last inspection. As a result of the provider's failure to address this known shortfall the person's risks remained inadequately managed.
- The provider continued to demonstrate poor management around staff recruitment. At our last inspection we found a member of staff had been employed despite being on a barring list as the result of an offence involving a child. At this inspection we found a member of staff in post who did not have a risk assessment in relation to a recent conviction for violence and who also did not have any appropriate employment references.
- The provider's quality assurance processes were not always fit for purpose. We found that office-based staff regularly completed quality monitoring forms. These were largely tick box exercises that failed to identify problems we found or to resolve them. For example, the monitoring form had a tick confirming a person had a risk assessment and care plan in place, even though both were inadequate. Similarly, a tick form for spot checks failed to note the urgent need to address this issue.
- The provider's quality assurance process failed to identify and rectify inaccurate management records. For example, rotas showed that staff members had been allocated visits at the same time for different people. The administrator informed us this was a typo. Similarly, we were told it was an error when we found a supervision record for a person the registered manager said had never worked for the provider.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014."

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

● The provider was not open when things had gone wrong. Following the death of a person using the service, complete and accurate care records were not available in the person's home. One health and social care professional told us, "Paperwork within [the person's] home is non-existent." At the time of our inspection we found that all relevant care records and staff files held at the provider's office had been destroyed.

● The provider did not present an accurate picture of all its practices to the public. For example, the provider's website states, "Here at Angel Solutions, our staff are directly employed by us and they go through vigorous security and vetting checks before they are allowed to visit clients or service users' homes." We found this was not the case at this inspection or at the last inspection. In both instances staff were sent into people's homes without risk assessments for criminal convictions and without appropriate references being taken up.

● The provider was not open and honest with us during the inspection. When we found a member of staff had been employed without references we were told the staff member had not been allowed to work until they obtained them. However, when we reviewed five weeks of rotas we found the provider had sent this potentially unsuitable member of in to be people's homes on 29 consecutive dates up to and including the date of our inspection. The member of staff had been subject to disciplinary action, as a result of their behaviour, days before we inspected.

The provider failed to act in an open and transparent way with relevant persons. This is a breach of regulation 20 (Duty of Candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The provider was inadequate when engaging with other agencies. For example, one health and social care professional described, "Months of not being able to engage [with the provider who was] not responding to any correspondence." Another health and social care professional told us the provider, "Do not keep us informed of any changes or issues."