Mrs Tanya Michelle Upsall

The Angels on Call

Inspection report

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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:
The Angels on Call is a domiciliary care service. It is registered to provide personal care to people living in their own homes in the community. The service operates in and around Boston, Lincolnshire.

Not everyone who used the service received personal care. The Care Quality Commission (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. At the time of our inspection, 13 people were receiving a personal care service.

People's experience of using this service and what we found:
The provider was still failing to effectively assess, monitor and improve the quality of the service and to assess and manage a range of potential risks to people's safety and welfare.

The provider's response to the COVID-19 pandemic was inconsistent and increased risks to people's health. There were continuing shortfalls in staff training, recruitment and the management of people's medicines.

We identified further concerns about the registered person's honesty, trustworthiness and reliability and her fitness to carry on the regulated activity. Some invoicing systems were ineffective and unsafe.

More positively, action had been taken to improve the deployment of staffing resources and the scheduling of people's care calls. Staff now received regular supervision and systems to promote organisational learning had been strengthened. Care plans and individual risk assessments were now reviewed on a monthly basis.

Everyone we spoke with was satisfied with the care and support they received and told us they liked and respected the registered person. Staff were happy in their work and spoke positively of the leadership provided by the registered person.

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 Inadequate (published 16 December 2020) and there were multiple breaches of regulation. The provider told us after the last inspection what they would do to improve. At this inspection we found insufficient improvement had been made and the provider was still in breach of regulations.

Why we inspected:
This was a planned inspection to follow up the findings of our last inspection. The inspection was focused on the key questions of Safe and Well-led. Ratings from previous comprehensive inspections for the key

questions of Effective, Caring and Responsive were used in calculating the overall rating at this inspection.

The overall rating for the service remains Inadequate. This is based on the findings at this inspection.

Enforcement:
At this inspection we have identified continued breaches of regulations in relation to the assessment and management of potential risks to people's safety; recruitment; organisational governance and the character of the registered person.

In response to these breaches we have retained the additional conditions of registration imposed after our last inspection. Please see the end of this report for further details.

Follow up:
We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

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

If the registered person 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 registered person from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of 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 re-inspect it and 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.

The Angels on Call

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
Our inspection was conducted by two inspectors and an 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:
The Angels on Call is a domiciliary care service, registered to provide personal care to people living in their own homes in the community.

The service was managed on a full-time basis by the owner who worked in the service on a daily basis, both in the office and delivering care. The owner was the registered provider with legal responsibility for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
We gave the service 72 hours' notice of our site visit. This was because it is a small service and we needed to be sure the owner ('the registered person') would be in the office to support the inspection.

What we did before the inspection:
In planning our inspection, we reviewed information we had received about the service. This included notifications submitted to CQC. Notifications are events which happened in the service that the registered provider is required to tell us about.

During the inspection:
We conducted our inspection between 30 March and 7 April 2021.

During our inspection we spoke with the registered person; the administrator; three members of the care

staff team and 15 service users and relatives.

We reviewed a range of written records including three people's care plan, five staff recruitment files, staff training records and information relating to the auditing and monitoring of service provision.

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 we were not assured that people were always safe and free from the risk of avoidable harm.

Preventing and controlling infection; Using medicines safely; Assessing risk, safety monitoring and management; Learning lessons when things go wrong.

At our last inspection the provider had failed to properly assess and manage a range of potential risks to people's safety. 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.

• The provider's response to the COVID-19 pandemic was inconsistent and increased risks to people's health. The registered person confirmed that not all care staff were taking weekly COVID-19 tests, despite her being aware this did not reflect current government guidance for domiciliary care providers. Additionally, one member of staff had declined to be vaccinated against COVID-19 but was still providing personal care to service users, many of whom were elderly and/or clinically vulnerable. The registered person had not assessed the risks associated with this staff member continuing to provide care and had not told everyone who used the service that they might be cared for by an unvaccinated staff member.
• More positively, people told us that staff always wore personal protective equipment (PPE) to reduce the risk of infection. One person said, "They put everything on before they come in the house. Then they take it off when they go out."
• At our last inspection, we found shortfalls in the management of people's medicines. At this inspection, people provided mixed feedback about the safety of the provider's approach in this area. For example, one person told us, "It's very organised and they always make sure I've taken [my medicines] .. I watch them write it all down so its recorded." However, another person expressed their concerns about the medicines administration practice of some staff, telling us, "Last week I found a tablet on the floor … I didn't know if it came from the morning or tea time. I binned it."
• Since our last inspection, the provider had introduced a new medicines administration record (MAR) audit, to improve the safety of medicines administration. However, over six months after we had first identified our concerns, the provider had only completed six of the eleven MAR audits identified as required, increasing potential risks to people's safety. Additionally, two members of staff employed since 2017 had still to undertake the provider's mandatory online Safe Administration of Medicines course, further increasing risks to people's safety and welfare.

The provider's ongoing failure to properly assess and manage potential risks to people's safety was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• At our last inspection, we identified concerns with the provider's approach to care planning and individual risk assessment. At this inspection, we were pleased to find improvements had been made. For example, people's individual risk assessments were now reviewed on a monthly basis and updated as required. In response to the findings of our last inspection, the provider had also taken action to improve the provision of staff supervision and had introduced a new system to promote organisational learning from significant incidents and events.

Staffing and recruitment

At our last inspection the provider had failed to take proper steps to ensure new recruits were suitable to work with vulnerable adults. 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.

• At our last inspection, we found the provider had employed two members of staff with extensive criminal records, without undertaking risk assessments to determine if either was suitable to work with vulnerable adults. In response, the provider had completed retrospective risk assessments for both employees. However, at this inspection we found the provider had subsequently employed another employee with previous criminal convictions. Despite the concerns identified at our last inspection, the provider had not undertaken a risk assessment of this person's suitability to work with the people who used the service, increasing the risk of harm.

The provider's ongoing failure to take proper steps to ensure new recruits were suitable to work with vulnerable adults was a continued breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had failed to ensure the safe and effective deployment of staffing resources and scheduling of care calls to meet people's needs. This was a breach of Regulation 18 (Staffing) 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.

• Since our last inspection, the provider had started to make better use of the online system used to schedule and monitor people's care calls. Action had also been taken to ensure sufficient staff were employed to meet people's needs and to improve the consistency of staffing arrangements.
• Reflecting these changes, almost everyone we spoke with told us they were satisfied with the provider's deployment of staff and scheduling of their care calls. For example, one person said, "They come four times a day and their timing is pretty good." Another person's relative told us, "It's the same two or three [staff] who come [each time] and [name] has got used to them. Sometimes a new one has come but with an existing carer."
• Commenting on the improvements made in this area since our last inspection, one person said, "[When I started using this company], I was a bit apprehensive. Sometimes no-one turned up and I had to ring to [ask]

where are they. Now it's much better. I feel I can rely on them more." A staff member told us, "Timings have definitely improved [and] I now tend to see the same clients. That's got better."
• Two people told us of their concerns that the provider sometimes sent two staff for half the scheduled length of the call, rather than one person for the full scheduled length. One relative told us, "I'd rather have one for the hour than two for half an hour. It may be quicker for them but it's not what we want. We specifically requested an hour in the morning as we want [name] to have the time to relax. If it's half the time, there is a sense of rushing." We raised this issue with the registered person who said she would take action to address it.

Systems and processes to safeguard people from the risk of abuse
• People told us they trusted the staff who came to their home. For example, one person said, "I do feel very safe, they're very nice people. I would soon finish with them if they weren't."
• However, the provider had failed to comply with the regulatory requirement to provide staff with safeguarding training. Only 23% of staff had completed the provider's online Safeguarding Adults training course, increasing the risk that abuse might go undetected or reported.

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 has remained the same.

This meant there were widespread and significant shortfalls in service leadership and governance. 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.

At our last inspection the provider had failed to assess and monitor the quality of the service and take action to address a wide range of potential risks to people's safety and well-being. This was a 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 our last inspection, the registered person told us, "I've not done [any] audits, the stuff I'm supposed to do." Since then, the registered person had employed an administrator and implemented new systems to monitor and improve the safety and effectiveness of the service. For example, a new medicines audit had been introduced and care plans were now reviewed and updated regularly.
• However, despite this increased focus on quality assurance, significant shortfalls in organisational governance remained. For example, the provider had failed to pick up and address the concerns we identified in areas including recruitment, medicines management and infection prevention and control.
• At our last inspection, we found significant shortfalls in the provision of staff training. At this inspection, we found little evidence of improvement. Most induction and refresher training was delivered online and when we reviewed online training records we found that only 21% of core training courses had been completed.
• This extremely low rate of compliance meant people were still exposed to the risk that staff might lack the skills and knowledge to care for them safely and effectively. For example, despite the COVID-19 pandemic, less than 50% of staff had completed the provider's online Infection Control training course. Similarly, almost 40% of staff had not completed the Moving and Positioning People course; over 75% had not completed Nutrition Awareness and over 90% had not completed Pressure Ulcer Prevention.
• The administrator and registered manager both acknowledged they had limited expertise in the use of computers. This had a detrimental impact on the effective management of the service. For example, neither the administrator nor the registered manager knew how to generate the standard 'training matrix' report from the online training system, limiting their ability to monitor and address the very significant shortfall in staff training compliance.
• The administrator also told us he did not know how to generate all the reports available from the online

call scheduling system, limiting the provider's ability to properly monitor the deployment of staff and the delivery of care calls. The administrator said he had managed to generate one weekly report from the system, to analyse any care calls that had not been automatically logged in the system. However, he told us it was a time-consuming process and, as a result, he had not generated this weekly report since 8 February 2021, almost two months before our inspection.
• We also identified instances of poor internal communication which further compromised the effective management of the service. For example, the registered person told us she knew that one recent recruit had a criminal record. However, the administrator told us he was unaware of this information, despite being responsible for pre-employment checks.
• Similarly, the administrator told us he had introduced a 'corrective action and preventive action' form in December 2020, to promote organisational learning from significant incidents. However, the registered person told us she was unaware of this new system, limiting its effectiveness.
• The provider's system for invoicing service users for shopping undertaken on their behalf by staff, was ineffective and unsafe. For example, one service user had been invoiced for £30 more than the cost of the goods that had been purchased for them. The administrator told us this was to cover the cost of staff time. This additional amount was not itemised on the invoice and there was no record of these hours being worked by, or paid to, the staff member concerned, increasing the risk of financial abuse.

The provider's persistent failure to assess, monitor and improve the quality of the service and to maintain effective organisational governance arrangements 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.

At our last inspection the registered person had failed to demonstrate her good character in the carrying on of the regulated activity. This was a breach of Regulation 4 (Requirements where the service provider is an individual or partnership) 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 4.

• The registered person was still frequently contradictory and unreliable in her responses to our inspectors' questions. For example, the registered person initially told us she had reflected on the findings of our last inspection and decided she would no longer employ staff with a criminal record. Later in our inspection visit, she acknowledged that she had in fact employed a new staff member with criminal convictions. Similarly, the registered person told us that "all staff" had completed their online medication training. However, as described in the Safe section of this report, when we reviewed the record of online training, we found that two long-serving employees had not completed this core training.
• Describing the induction process for new staff, the registered person told us staff "had to" undertake both online and hands-on training in medication and moving and handling, before they started delivering care. Talking about the most recently recruited employee, the registered person said, "[Name] has done [her] e-learning training. I always ask for that." However, when we reviewed the record of online training, we found this staff member had not completed their online moving and handling training until 3 April 2021, two days after we had raised the issue with the registered person during our inspection visit.
• We talked to the registered person about an incident that had happened shortly after our last inspection visit. During that inspection we had discussed a very serious allegation of multiple missed care calls to a particular service user. The day after that inspection visit, someone had accessed the provider's electronic call monitoring system using the registered person's login details and deleted all data relating to the service

user. Although the registered person continued to insist this potentially important evidence had been deleted without her knowledge, she acknowledged that her explanation of what had happened sounded "a bit dubious".

These further concerns about the registered person's honesty, trustworthiness and reliability and her fitness to carry on the regulated activity was a continued breach of Regulation 4 (Requirements where the service provider is an individual or partnership) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found the provider had failed to notify CQC of significant incidents and events which had occurred in the service. This was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

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

• In planning this inspection, we identified there had been no notifications received from the provider since our last inspection. We discussed this with the registered person and were satisfied she understood this aspect of her regulatory responsibilities and that there had been no notifiable incidents or events since our last inspection.

Engaging and involving people using the service, the public and staff; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others
• Everyone we spoke with during our inspection told us they thought the service was well-managed. For example, one relative told us, "[Name] always has a lovely smile on her face again. I feel they know what they're doing, and I am consulted. It's like a family looking after [name]. I'd give them 9.5 out of 10." Another relative said, "I would [recommend them]. The girls that come are good and caring. They have a good chat with [name] and she enjoys that."
• The registered person maintained a very hands-on, visible presence and appeared well-liked and respected by everyone who used the service. For example, one relative told us, "She cares. It's the first thing about her that comes out. She's bright and bubbly [and] talks to [name] properly and respectfully." Another relative said, "We always deal with [the registered person] if we need anything. I always feel that [name] is safe and happy and that [the registered person] knows what she's doing."
• People also told us they felt involved in the planning and delivery of their care. For example, one person said, "They talked to me from the start and I make the decisions. I've always decided what I want."
• The registered person still worked regularly as a member of the care team and appeared respected and admired by her team. For example, one staff member told us, "[The registered person] bends over backwards to help us. She's a brilliant boss."
• The registered person and her staff continued to maintain a range of professional contacts on behalf of the people in their care, including with GP's and community nurses.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider was still failing to properly assess and manage potential risks to people's safety.

The enforcement action we took:

We retained additional conditions of registration imposed following our last inspection.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was still failing to assess, monitor and improve the quality of the service and to maintain effective organisational governance arrangements.

The enforcement action we took:

We retained additional conditions of registration imposed following our last inspection.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider was still failing to take proper steps to ensure new recruits were suitable to work with vulnerable adults.

The enforcement action we took:

We retained additional conditions of registration imposed following our last inspection.

Regulated activity	Regulation
Personal care	Regulation 4 HSCA RA Regulations 2014 Requirements where the service providers is an individual or partnership We identified further concerns about the registered person's honesty, trustworthiness and reliability and her fitness to carry on the regulated activity.

The enforcement action we took:

We retained additional conditions of registration imposed following our last inspection.