Angel Solutions (UK) Ltd

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:
•Angel Care Solutions (UK) Ltd is a domiciliary care agency that provides personal care to people in their own homes. At the time of our inspection the service was delivering support to eight people.
•The service supports people with a range of needs including physical and mental health needs.

People's experience of using this service:
•The quality of care people received had significantly deteriorated since the last inspection.
• People were not safe as the provider had recruited and deployed unsafe and unsuitable staff to deliver care and support in people's homes.
• People who presented with behavioural support needs were not protected from avoidable harm because risk assessments were inadequate and did not provide staff with the guidance they required.
• People's medicines were poorly managed. Audits were not carried out of one person's medicines and the medicines administration records for another person contained unexplained gaps.
• Staff were not adequately trained and staff training records were inaccurate.
•The service was poorly managed. Weak systems and inadequate management meant the provider failed to identify and act upon the shortfalls we found.
•Notwithstanding our findings, people were positive in their comments about the service they received.
• The service met the characteristics of 'inadequate' in two of the key areas we inspected and therefore 'inadequate' overall.
•We identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 around people's safety, staffing and the management of the service. You can see what action we told the provider to take at the back of the full version of this report.

Rating at last inspection:
•The service received an overall rating of 'requires improvement' at our last inspection which was published on 12 March 2018.

Why we inspected:
•This was a planned inspection based on the rating at the last inspection.

Enforcement:
In respect of this inspection full information about CQC's regulatory response to the more serious concerns found in inspections and appeals is added to reports after any representations and appeals have been concluded.

Follow up:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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 safe.

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was Caring.

Details are in our Caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive

Details are in our Responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our Well-Led findings below.

Inadequate

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by one inspector and one 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. Their area of expertise is dementia care.

Service and service type:
Angel Solutions (UK) Ltd is a domiciliary care agency providing personal care to people living in their own homes. It provides this service to older adults, younger adults with physical disabilities, people with mental health needs and children.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
The inspection took place on 7 and 13 March 2019 and was announced. We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in. We visited the office location to see the registered manager and office staff and to review care records, staff files, policies and procedures.

What we did:
Before the inspection, we reviewed:
•The information we held about the service
•The provider information return
•Notifications the provider is required by law to send us about important events that happen within the

service.

During the inspection, we reviewed:
• Five people's care records which included their needs assessments, support plans, risk assessments and medicines administration records.
• Five staff files which included recruitment and training information as well as records of staff supervision and appraisal meetings
• Records of training including training certificates and the provider's training matrix.
• Records related to accidents, incidents and complaints.
• Records related to the provider's quality assurance processes.
We spoke with:
• Three people using the service and one relative
• Two care staff
• The care coordinator
• The registered manager
• The director

After the inspection, we:
• Contacted three health and social care professionals for their views regarding the service.

Inadequate

Is the service safe?

Our findings

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

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Staffing and recruitment

- The provider sent staff into people's homes who were not safe to deliver care and support to people.
- As part of its recruitment process the provider reviewed checks carried out by the Disclosure and Barring Service (DBS). The DBS provides details of criminal convictions and individuals barred from working in adult social care. This enables providers to make safe recruitment decisions. We found one member of staff whose DBS check confirmed they were barred from working with vulnerable adults and children. The provider had sent this member of staff into people's homes to deliver personal care. After we brought this failing to the provider's attention they took steps to stop the member of staff from working with people immediately.
- The provider failed to obtain employment references for two staff including the member of staff on the DBS barred list.
- By failing to accurately establish the complete employment histories of these staff the provider was unaware of their conduct in previous roles, the circumstances under which they left previous employment or whether they posed a risk to people.
- The provider failed to protect people from the risk of abuse by employing unsuitable staff.

The failure to ensure that fit and proper persons are employed is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People's risks were not always adequately assessed and plans in place did not always reduce risks.
- Where people presented with behaviours which may challenge, staff did not have adequate guidance in care records. For example, to support one person when they became physically challenging, the guidance to staff in care records was, "Handle with care." There was no information for staff about the strategies or techniques they should use to keep the person or themselves safe.
- Staff did not receive training to manage people's behavioural support needs. This meant staff did not have the skills or knowledge to deescalate people's agitation or the appropriate actions to take in line with best practice when behaviours escalated.
- The provider did not operate any systems to monitor behaviours which may challenge. This meant the provider did not know the frequency, duration or intensity of people's behaviours.
- The registered manager and the office team did not learn from incidents where behaviours occurred. The registered manager did not undertake any analysis of incidents to identify triggers, the process of escalation or the impact of staff responses.
- Risk assessments were not updated following behavioural incidents to reflect recent information.
- The provider failed to make appropriate referrals to healthcare professionals specialising in behavioural support needs to provide staff with guidance's to manage people's behavioural needs safely and to reduce

the risk of incidents recurring.

The failure to assess the risks to people's safety and to do doing all that is practicable to mitigate them is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● The provider did not ensure that people received their medicines safely.
● The registered manager and office based staff failed to maintain accurate records related to people's medicines. For example, the Medicine Administration Record (MAR) chart for one person contained eight unexplained gaps in a two-week period. No codes had been entered into the MAR charts to indicate reasons for the gaps such as refusal, the person being in hospital or on holiday. The provider failed to establish the reason for the gaps in recording or to determine if people had received their medicines as prescribed.
● No follow up activity was undertaken or recorded by the registered manager to determine why the MAR charts were not appropriately completed.
● There were no MAR charts available at the provider's office for a second person and no medicines audits had been undertaken at their home. This meant the provider did not know if the person was receiving their medicines safely and in line with the prescriber's instructions.

The failure to provide proper and safe medicines management is a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Notwithstanding our findings people told us they felt safe receiving care and support from the staff of Angel Care Solutions (UK) Limited.
● One person told us, "I was worried about people coming in, but they have negated my fears."
● Another person said, "I feel safe. Nothing ever goes missing."

Preventing and controlling infection
● People were protected from the risk and spread of infection.
● One person told us, "Gloves and aprons are always worn."
● Staff were issued with personal protection equipment (PPE) to prevent the risk and spread of infection when delivering personal care. PPE included aprons, gloves and shoe covers that were disposed of after each use.
● Staff were also issued with anti-bacterial hand sanitising gel. Staff told us they regularly collected PPE form the provider's office and ensured enough of these items were stored, with people's consent, in their homes.

Requires Improvement

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

RI:□The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Staff support: induction, training, skills and experience

- At our last inspection we found the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff had not received appropriate training.
- Following our last inspection, the provider forwarded an action plan which set out how they planned to ensure staff were adequately trained.
- At this inspection we found continued failure on the part of the provider to ensure that staff received the training they required to deliver care and support effectively.
- One member of staff told us they had not received any training.
- We were shown a training matrix detailing the many training sessions staff had attended. However, we found that one member of staff had been on extended leave when the training matrix showed them to have completed over 20 training sessions. In another example the training matrix showed that one member of staff completed 21 training sessions including manual handling, medicines, health and safety, fire safety, first aid and safeguarding in a single day. This meant we could not be assured as to the accuracy of the provider's training records.
- The registered manager informed us that the provider's director delivered staff training. However, they were unable to provide evidence of the director's training and competence to deliver training to staff that was in line with best published practice.
- The registered manager informed us that the director delivered training in the building where the provider's office was located. However, no training materials such as training session plans, lecture notes, agendas, booklets or handouts were available on either day of our inspection.
- The registered manager did not know the location of the equipment required to deliver training to staff in the building. For example, during manual handling training, equipment such as hoists are required to teach staff safe moving and handling techniques. Similarly, specialist manikins are required when training staff in first aid and basic life support. The whereabouts of any other these materials where unknown to office staff.
- We were not assured that the provider had the materials or equipment to deliver training appropriately to staff.

The failure to provide staff with the appropriate training they require is a repeat breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- At our last inspection we found that people's needs were not appropriately assessed and recorded. At this inspection we found this had improved and people had needs assessments in place.

● People, their relatives and health and social care professionals participated in needs assessments. One person told us, "The social worker came to see me and my [family member]. Then a manager and carer came to see me."
● The provider undertook initial assessments prior to people receiving a service. This was to make sure the provider had the ability to meet people's needs. Needs assessments covered areas including the support people required to eat, drink, wash, dress, mobilise, be active and to receive medicines. The provider arranged for people's needs to be reassessed regularly or when their needs changed.

Staff support:
At our last inspection we found that staff were not receiving supervision or appraisal. At this inspection we found that staff were attending quarterly supervision meetings and annual appraisals. One member of staff told us, "In supervision we discuss the challenges I face and what I need to do."

Supporting people to eat and drink enough to maintain a balanced diet
● Care records noted the support people required to eat and drink. Where people ate and drank independently this was noted. Care records noted people's food and drink preferences. For example, one person's care records noted they, "Prefer cooked meals over microwave ones."

Staff working with other agencies to provide consistent, effective, timely care
Supporting people to live healthier lives, access healthcare services and support
● People were supported in line with their assessments to remain healthy.
● Staff supported people to access healthcare services when required and the details of contacts with healthcare professionals were noted in care records. For example, where people required healthcare professionals to administer daily medicines this was noted in care records.
● Staff took action when they identified changes to people's needs. One member of staff told us, "I let the office staff and the GP know if people's health needs change. Say someone's skin is reddening you have to report it straight away and do what the nurse and doctor says."

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 Act 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 with appropriate legal authority. We checked whether the service was working within the principles of the MCA.

● The registered manager and care coordinator explained to us that people had capacity to consent to their care so no MCA assessments had been necessary.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect
RI:□People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; respecting equality and diversity
● The provider failed to do all that they could to ensure people were well treated.
● The provider sent unsafe and poorly trained staff to deliver care to people in their homes. We have detailed the impact of these breaches within the 'Safe' and 'effective' key questions of this report.
● Notwithstanding our findings, people told us that the staff supporting them were caring.
● One person said, "I have had the same carer for three years. They are like family to me. She knows my needs very well." Another person told us, "If I am not feeling too well, before they leave they will call my [family member]."
● Staff respected people's cultural and spiritual needs. One person told us, "On Sundays the carer comes in early to get me ready and help me downstairs. Then a church member takes me to church."
● Care records guided staff around supporting people to maintain the relationships that were important to them.
● For example, one person's care records noted that it was important that staff enable them to talk about their relatives and friends.
● Another person's care records noted how important their relationship with their cat was and guided staff to regularly reassure them about its well-being and whereabouts.

Supporting people to express their views and be involved in making decisions about their care
● Staff enabled people to make decisions about the care and support they received.
● People were supported to make choices such as the clothes they wore, what they ate and what they did.
● People, with the support of health and social care professionals, decided the times of day when they wanted their care and supported to be provided by care staff. The provider ensured this happened.

Respecting and promoting people's privacy, dignity and independence
● People told us that staff maintained their dignity.
● One person told us, "The care is always dignified."
● Staff promoted people's independence in line with their needs and preferences. One person told us, "[Staff member] tries to keep me independent and encourages me to try."
● People felt that staff treated them and their homes with respect and maintained their privacy.
● One person told us, "[Staff member] always calls to say, 'I am coming to your door now', so that I will not be anxious."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

RI:□People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● People's care was not always planned to meet their assessed needs. Where people presented with behaviours which may challenge, staff did not have guidance in care records to respond appropriately. We have detailed the impact of this breach within the 'Safe' key question of this report.

● People participated in the development of their care plans. People's care records detailed how their assessed needs should be met. People and where appropriate, their relatives, participated in the creation and review of care plans. One person told us, "I have a review every six months."

● Care records reflected people's preferences for how their care and support should be provided

● People's care records stated the agreed planned outcomes for their care.

● For example, one person's care records noted the desired outcome from their support was for their personal hygiene needs to be met.

● Care records noted people's preferred times for receiving care and support. People told us that staff adhered to these.

● Care records also informed staff as to people's needs and preferences regarding entry to their homes. Where key safes were required details were made available to staff on a need to know basis.

● People's care records noted where they received informal support from relatives and friends. Care records also noted were care was delivered by other providers. This meant people, relatives and staff were clear about their roles.

Improving care quality in response to complaints or concerns

● The provider had a complaints procedure in place and maintained a record of complaints received. No complaints had been made since the last inspection.

End of life care and support

● None of the people receiving care and support from Angel Solutions (UK) Ltd at the time of our inspection had been assessed as requiring end of life care.

●The registered manager told us that they would make a referral for an assessment by healthcare professionals if people required end of life care. This assessment, along with people's preferences, would inform their end of life care plan.

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

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support with openness; how the provider understands and acts on their duty of candour responsibility; and managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:

- At our last inspection of Angel Solutions (UK) Ltd in 2018 we found the provider's quality assurance processes failed to identify shortfalls we identified. The provider's shortfalls included poor staff training, care records and quality audits. Following our last inspection, the provider sent us an action plan which detailed how they intended to make improvements.
- At this inspection we found that governance of the service had deteriorated.
- The registered manager failed to audit staff records.
- People were at risk of abuse and improper treatment because the provider had employed a member of staff who was barred from working with vulnerable adults and children. The provider's failure to carry out quality checks of staff records resulted in a failure to discover that this unsuitable and unsafe member of staff was also working without any employment references.
- People received care from a provider that failed to carry out appropriate audits of the service being delivered.
- For example, the registered manager failed to gather and check the medicines records of one person.
- For another person staff retrieved their medicines records and took them to the office but office staff failed to audit them appropriately. This meant they failed to identify the multiple occasions where medicines records had not been signed or to take any action as a result.
- The registered manager failed to audit care records which lead to a failure to address and resolve shortfalls within them.
- For example, one person's care records did not contain any appropriate guidance to staff on managing behaviours which may challenge. Without appropriate guidance both the person and staff were at risk of injury.
- The registered managed failed to maintain accurate records related to staff. We were presented with a training matrix which was inaccurate and contradicted by staff who told us they had not undertaken the training stated on the matrix.
- The registered manager did not have appropriate oversight of the service. The failure of the registered manager and office team to conduct robust audits meant that they did not identify and address the shortfalls we found.
- The office based management team consisted of a registered manager, director and care coordinator. Whilst the management team were clear about their roles they lacked knowledge with regards the regulatory activity they were directing. For example, the management team did not understand that

promoting and supervising people around tasks such washing, dressing, toileting and eating fell within the definition of personal care. As a result, the management team were unclear about the number of people they were delivering the regulated activity of personal care to and lacked oversight. We established that Angel Solutions (UK) Ltd were providing personal care to eight people before we concluded our inspection.

The failure to assess, monitor and improve the quality and safety of the service is a repeat breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

- The service sought feedback from people through quarterly written surveys.
- One person told us, "A senior member of staff comes to see me and I have a paper questionnaire to fill in."
- The registered manager conducted spot visits to people's when they observed staff delivering care and support and asked people for their views. One person told us, "The manager calls to see how things are going every three months." A member of staff told us, "Spot checks keep us on our toes. We don't know they are going to happen. The registered manager checks to see we are wearing our uniforms and supporting people right."
- People we spoke with knew the names of the manager and office staff and expressed confidence in them.
- The registered manager coordinated monthly team meetings. These meetings were attended by the senior management team and care staff. One member of staff told us, "We discuss how the work goes on. It helps when policies get explained." Another member of staff said, "It is good to meet team mates." We reviewed the records of five team meetings and found issues discussed included people's needs, lone working, time keeping and emergency procedures.

Continuous learning and improving care; Working in partnership with others.

- The service interacted with a number of other agencies and professionals including social workers, commissioning teams and healthcare professionals.
- The registered manager informed us that the service attended local authority provider forums where good practice in the delivery of care was discussed. Despite this, the service has continued to deteriorate.