Angel Home Care Consultancy Limited

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Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on the 1 May 2018 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. The service first became operational in November 2017. It has been registered at its current location since October 2017. This was the first inspection of the service.

Angel Home Care Consultancy Ltd is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. At the time of the inspection it was providing a service to three people.

There was a registered manager at the service at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Relatives told us they felt the service was safe, staff were kind and the care received was good. We found staff had a good understanding of their responsibility with regard to safeguarding adults.

Risk assessments were in place which provided guidance on how to support people safely. Medicines were managed in a safe manner. There were sufficient numbers of suitable staff employed by the service. Staff had been recruited safely with appropriate checks on their backgrounds completed. People were protected by the prevention and control of infection.

Staff undertook training and received regular supervision to help support them to provide effective care. However we found supervision records were generic and lacked detailed for personal development. We have made a recommendation about supervision.

Staff we spoke with had a good understanding of the Mental Capacity Act 2005 (MCA). MCA is law protecting people who are unable to make decisions for themselves. People who had capacity to consent to their care had indicated their consent by signing consent forms

Person centred support plans were in place and people and their relatives were involved in planning the care and support they received.

People's cultural and religious needs were respected when planning and delivering care. Discussions with staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people could feel accepted and welcomed in the service.

The service had an end of life policy for people who used the service. However the service did not explore people's end of life wishes during the initial needs assessment and care planning. We have made a

recommendation about supporting people with end of life wishes.

The provider had a complaint procedure in place. People and their relatives knew how to make a complaint.

Staff told us the registered manager was respectful, knowledgeable and communicated well. The service had various quality assurance and monitoring mechanisms in place.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff were able to explain to us what constituted abuse and the action they would take to escalate concerns.

Risk assessments were in place which set out how to manage and reduce the risks people faced.

Medicines were recorded and administered safely.

Staff were recruited appropriately and adequate numbers were on duty to meet people's needs.

People were protected by the prevention and control of infection.

Is the service effective?

Good

The service was effective. Staff undertook regular training and regular supervision. However supervision records were generic and not detailed.

The provider met the requirements of the Mental Capacity Act (2005).

Staff were aware of people's dietary preferences. Staff had a good understanding about the current medical and health conditions of the people they supported.

Is the service caring?

Good

The service was caring. People that used the service told us that staff treated them with dignity and respect.

People and their relatives were involved in making decisions about the care and the support they received.

Staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people could feel accepted and welcomed in the service.

Is the service responsive?

Good

The service was responsive. People's needs were assessed and care was planned in line with the needs of individuals. People and their relatives were involved in planning their own care.

The service had a complaints policy and relatives knew how to make a complaint.

The service had an end of life policy for people who used the service. However the service did not explore people's end of life wishes during the initial needs assessment and care planning.

Is the service well-led?

Good

The service was well-led. The service had a registered manager in place. Staff told us they found the registered manager to be respectful, knowledgeable and communicated well.

Relatives told us that the service was well run and they received good care.

The service had various quality assurance and monitoring systems in place.

Angel Home Care Consultancy Ltd

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 was planned to check whether the 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.

This inspection took place on 1 May 2018 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. The inspection team consisted of two inspectors.

Before we visited the service we checked the information we held about the service and the service provider. This included any notifications and safeguarding alerts. A notification is information about important events which the service is required to send us by law. The inspection was informed by feedback from professionals which included the local borough contracts and commissioning team that had placed people with the service, and the local borough safeguarding adult's team. We reviewed the information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. The inspection was informed by feedback from questionnaires completed by one person who used the service and one relative. Feedback from the questionnaires were positive about the service.

During our inspection we spoke with the registered manager, the nominated individual and three staff members who provided support to people. We were unable to speak to people who used the service because they were verbally unable to communicate with us. We spoke to three relatives of people who used the service during the inspection. We looked at three care files which included care plans and risk assessments, four staff files which included supervision records and recruitment records, quality assurance records, one medicines record, training information, policies and procedures, and complaint information.

Good

Is the service safe?

Our findings

Relatives told us they felt the service was safe. One relative told us, "I feel safe with [staff] looking after [relative]."

Staff knew how to make people safe. Staff understood what abuse was and gave examples of different forms of abuse. Staff knew what they needed to do if they suspected abuse was taking place. Staff told us they would report any witnessed or suspected abuse to the registered manager. Staff also knew to report any witnessed or suspected abuse to external organisations if this would be in the best interest of the person receiving support. One staff member told us, "I would report to the office. If no action, would inform in the local authority." All staff had received up to date training in safeguarding adults from abuse. The organisation's safeguarding and whistleblowing policies and procedures were contained in the staff handbook which was given to all new members of staff when they first joined the service. Staff were aware of their rights and responsibilities with regard to whistleblowing.

Records showed there had been no safeguarding incidents since the service started providing care. The registered manager was able to describe the actions they would take when an incident occurred which included reporting it to the Care Quality Commission (CQC) and the local authority safeguarding team. The registered manager said, "I would get all the information and send to the local authority and CQC. We have all the safeguarding numbers." This meant that the provider would report safeguarding concerns appropriately.

Individual risk assessments were completed for people who used the service. Risk Assessments covered areas such people's health needs, mobility, personal care, communication, nutrition, medicines, moving and handling and daily living skills. All risk assessments were specific to the individual and included information for staff on how to manage risks safely. For example, one person was assessed as being wheelchair bound. The risk assessment gave guidance about how to safely manage transfers, moving and handling and how to use appropriate equipment in both written and picture form. Staff we spoke with were familiar with the risks that people presented and knew what steps were needed to be taken to manage them. Risk assessment processes were effective at keeping people safe from avoidable harm.

Accident and incident policies were in place. There had been no accidents or incidents reported since the service started providing care. Staff we spoke with understood their responsibilities to raise concerns, record incidents and report them both internally and externally where appropriate. One staff member told us, "I would report to the manager." A second staff member said, "I would document everything."

One person received support with their medication. One relative told us staff helped the person by, "Taking the medication out of the blister pack and putting it in a cup for [person] to take." For the person who needed support to manage their medicines, information had been included in their individual needs and care plan and medicines risk assessment. This information included the strength and dosage, and what time of day each medication should be taken. All staff spoken with had completed training in the administration of medicine. Records confirmed this. Staff told us that if they had any concerns about medicines, for

example a change or effectiveness of prescription they would discuss this with the individual they were supporting and their family members, the registered manager and liaise with the pharmacy directly. Medicines administration records (MAR) were completed and signed by staff when people were given their medicines. Records confirmed this. The individual needs assessment, care plan and medicines risk assessment did not include further information about the medicines such as side effects and what the medicines were prescribed for. After the inspection the provider sent us a medicines profiles which gave specific details on each medicine including 'when required' (PRN) medicines. PRN medicines are to be taken as needed instead of on a regular dosing schedule.

Sufficient staff were available to support people. Staffing levels were determined by the number of people using the service and their needs, and could be adjusted accordingly. Relatives told us there was enough staff available to provide support for them when they needed it. One relative told us, "No lateness. Not a problem." Another relative said, "No lateness, [staff] not rushed." Staff told us they were able to provide the support people needed. One staff member told us, "Yes, enough staff." Another staff member said, "If [staff member] sick, [registered manager] will get cover. They did this recently within a few minutes."

The service had an out of hours on call system available. A staff member told us, "[Out of hours number] available on [care folder kept in people's homes]." Each person had the out of hours number available to them in their home. Relatives we spoke with knew how to contact the office on the out of hour's number. One relative told us, "I have a number to call if problems." This meant staff and people who used the service could get assistance, advice and support if needed outside of office hours.

The provider followed safe recruitment practices. Staff recruitment records showed relevant checks had been completed before staff worked unsupervised at the service. We saw completed application forms, proof of identity, references and Disclosure and Barring Service (DBS) checks. The DBS is a national agency that holds information about criminal records. Staff confirmed DBS checks were completed before they could work with people who used the service. This meant the provider had done all that was reasonable to ensure staff were suited to working in the caring profession.

Records showed staff had completed training on infection control. Staff had access to policies and guidance on infection control. Staff told us supplies of protective clothing were available which included gloves and aprons. One staff member told us, "We get given gloves and aprons." Another staff member said, "You get them [protective clothing] from the office." One relative said "They [staff members] always wear gloves". A second relative said "They [staff members] wash their hands and wear gloves." This meant people were protected from potential cross infection.

Good

Is the service effective?

Our findings

Relatives told us they were happy with the service they received and felt staff had the skills and experience to provide support. A relative told us, "Happy with everything." Another relative said, "The carers are excellent."

Before a person started to use the service the registered manager would carry out an assessment of their needs, before an agreement for placement was made. This was carried out to ensure that the service could meet the person's needs. Records showed that an assessment of their needs had been carried out for all the people who used the service. The assessment of needs looked at medical history, medicines, mobility, communication, toileting, nutrition and hydration, spiritual needs, social care needs and likes and dislikes. Relatives told us and records confirmed they were involved in the assessment process. Information was obtained from the pre-admission assessment, and reports from health and social care professionals had been used to develop the person's care plan. This helped staff to ensure that people received individualised care and support which took account of their wishes and preferences.

Staff were trained and supported to have the right skills, knowledge and qualifications necessary to give people the right support. A staff member told us, "I liked [training]. It was helpful." Staff we spoke with confirmed that they had received all of the training they needed. Records confirmed staff had received training for their role which would ensure they could meet people's individual needs. This included training in topics such as data protection, equality and diversity, emergency first aid, food hygiene, health and safety, moving and handling, pressure care, safeguarding adults, effective communication, continence promotion, infection control, fire safety, person centred care, mental health and dementia, and the Mental Capacity Act 2005 (MCA).

New staff that joined the service completed a five day induction programme which included shadowing more experienced staff. Staff we spoke with and records confirmed this. The registered manager told us they were in process of progressing new and existing staff to complete the care certificate. The care certificate is a recognised qualification that ensures that staff have the fundamental knowledge and skills required to work in a care setting.

Records showed staff received regular supervision. Supervision records showed discussions on people who used the service, training and the care certificate. However supervision records were generic and did not always contain sufficient detail to demonstrate what had been discussed. This meant staff development and support was not always appropriately explored and recorded through the supervision process.

We recommend the service seek and follow best practice guidance from a reputable source about supporting staff through supervision.

People were supported to have sufficient food and drinks. Some people required support with their meals. Care records showed how people's dietary needs were assessed, such as their food preferences and how they should be assisted with their meals. A relative told us, "[Staff] help with food if I am going out." Records

confirmed staff had received training in food hygiene and were aware of safe food handling practices when supporting people in their homes.

Staff were aware of what action to take if people were unwell or had an accident. They told us they would contact people's GP or phone for an ambulance as necessary and inform people's next of kin. Care records included contact details of GP's and relatives. Staff told us they worked with other healthcare agencies to promote people's health such as district nurses, pharmacists and GP's. One staff member said, "We keep in touch with the doctor sometimes. Spoke to the doctor about a prescription."

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.

The registered manager and staff had an understanding of the MCA and how the act should be applied to people living in their own homes. Consent to care and treatment forms in care files were signed by people who used the service. Family were involved in making decisions where people lacked capacity. Staff explained how they supported people to make choices about their daily lives. Staff also told us they spoke with people who used the service and family members to get an understanding of people they supported and their likes and dislikes. Records showed people and their relatives had been involved and consulted about various decisions and had confirmed their agreement with them. One staff member told us, "Always ask permission." One relative told us, "They [staff] talk to my [relative] nicely and explain everything."

Good

Is the service caring?

Our findings

Relatives told us staff were caring. One relative said, "[Staff] look after [relative] like a family member." Another relative told us, "[Staff] talk to my [relative] nicely.□

Staff told us that the people they supported had been with them for long periods of time so they knew them well. People who used the service had previously been with another agency and the same staff moved with them to Angel Home Care Consultancy Ltd. Staff spoke in a caring way about people they supported and told us that they enjoyed working at the service. One staff member said about their person they cared for, "I really love [person]. [Person] is so sweet." Another staff member told us, "I like working with [person]." A third staff member said, "I'm trying to do all my best for [person] to have a good life."

Care plans contained information about people's communication needs and preferences. This helped give staff the information they needed to build rapport with people in order to establish positive relationships with them. The provider continued this supportive approach in the way they introduced care workers to the people they cared for. Staff confirmed they visited people and completed shadowing before being allocated to work with people on a permanent or replacement basis. People had a preference for staff members of a specific gender and cultural background. Relatives and staff told us this was respected.

Care plans also contained a section called, "About my home and family." This included information about people's personal history, family and friends and home life. This enabled staff to gain a better understanding of people's background thereby creating positive relationships

Relatives told us privacy and dignity was respected. One relative said, "[Staff] close the door when washing [relative]." Staff we spoke with gave examples how they respected people's privacy. One staff member told us, "I call [person] [preferred name] which she likes." Another staff member said, "I close curtains and [close] doors for personal care." Care plans showed people's respect and dignity were recorded. For example, one care plan stated, "I like my home to be respected and things are not changed."

People's independence was encouraged. Staff gave examples how they involved people with doing certain aspects of their personal care to help become more independent. This was reflected in the support plans for people. For example, one care plan stated, "I would like to remain independent but I need help with my personal care and my daily activities." One staff member told us, "[Person] takes medicines herself with her hands. Wants to do [herself] even if it is hard. She tries."

Good

Is the service responsive?

Our findings

Relatives told us the service was responsive to people's needs. One relative said, "I am happy with [the care]."

The registered manager told us care plans were reviewed annually or if the person's needs changed. Records confirmed the service had processes in place to review people's care. However as the service had started providing care to people from November 2017 no care plan reviews had taken place. The registered manager told us one person had wanted more support with food preparation. Records showed the service had contacted social services to arrange a review of the care package to increase the hours of support.

Care plans contained detailed information and clear guidance about all aspects of a person's health, social and personal care needs, which helped staff to meet people's needs. The care plans covered nutrition, falls, skin integrity, washing and dressing, toileting, eating and drinking, communication and medical history. The care plans were person centred. For example, one person had specific food preferences. The care plan stated, "I enjoy having fruits (mashed), rice pudding, chocolate biscuits and yogurt."

People's care and support was planned proactively with them and the people who mattered to them. Relatives were fully involved, where appropriate, in identifying people's individual needs, wishes and choices and how these should be met. Records confirmed this. One relative said, "The care plan was done in front of [person using the service]." Another relative told us, "I know what is in [care plan]. I helped with it." Detailed care plans enabled staff to have a good understanding of each person's needs and how they wanted to receive their care.

The provider complied with the Accessible Information Standard by identifying, recording, flagging, sharing and meeting the information and communication needs of people with a disability or sensory loss. For example, one person was unable to verbally communicate. The person had various ways to communicate which included a communication alphabet board and body language. Care staff we spoke were able to describe how they communicated with this person. The care plan for this person stated, "[Person] communicates through body language. Thumb up for yes and thumb down for no. Also, [person] is using an alphabet sheet and communication board to help her communication." The relative of this person told us, "Carers manage alphabet board well. Signals with consent with thumbs up or down."

People's cultural and religious needs were respected when planning and delivering care which included specialised food preparation. Discussions with staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people (LGBT) could feel accepted and welcomed in the service. The registered manager told us, "When we do [initial] assessment we ask their preferences. We explain about LGBT in recruitment." A staff member told us, "Care is different for each individual but treat everyone the same." Another staff member said, "[I would] ask their choices and preferences."

The provider had a system in place to log and respond to complaints. There was a complaints procedure in place. This included timescales for responding to complaints and details of who people could escalate their

complaint to, if they were not satisfied with the response from the service. The complaints procedure was contained in the service user guide which was given to all new people when they first joined the service.

Relatives were aware how to make a complaint. One relative told us, "I know what to do." The registered manager told us they had received no complaints since the service had started providing care.

At the time of our inspection the service did not have any people receiving end of life care. The service did have an end of life policy for people who used the service. The policy was appropriate for people who used the service. The service did not provide end of life care training for staff. We spoke to the registered manager about this and we were advised training would be arranged for staff. Also the service did not explore end of life wishes during the initial needs assessment and care planning.

We recommend that the service seek advice and guidance from a reputable source, about supporting people with their end of life wishes to express their views and involving them in decisions about their care, treatment and support.

Good

Is the service well-led?

Our findings

Relatives we spoke with were positive about the registered manager and the service. One relative said about the registered manager, "Very impressed. [Registered manager is] diligent, calm, and knowledgeable." Another relative told us, "[Registered manager] is fine. Overall good, everything is fine." A third relative said, "All the time I speak with [registered manager]."

There was a registered manager in post. They were aware of their responsibilities as registered manager and of the need to notify CQC about reportable incidents. They told us there had been no reportable incidents since the service was registered. They had current policies and procedures in place to run the service.

Staff spoke positively about the registered manager. One staff member told us, "[Registered manager] is polite. Doesn't boss me around and respectful." A second staff member said, "Good and helpful. Explains things to me." A third staff member told us, "[Registered manager] very nice. Respects the carers. He explains everything right away."

The registered manager described in detail the support provided to people, and knew them, their preferences and needs well. They had built up a strong relationship with people who used the service and their relatives. The registered manager said about his role, "I have worked hard to make sure clients are quality monitored and forms filled out correctly. I'm reliable and prioritise my job." The attitude and approach of staff providing care was aligned with that of the registered manager. This demonstrated that a positive, person centred culture had been developed in the service.

Staff meetings were not being held. The registered manager told us this was because they had recently started providing care to people and most care staff were recruited in March 2018. The registered manager and records showed a staff meeting was to be held in June 2018.

The service involved people and their relatives in various ways for feedback on the service provided. This included spot checks to people's homes and telephone monitoring. The spot checks topics included observations, medicines, feedback from people who used the service and competency of staff members. Records confirmed this.

The registered manager told us the quality of the service was also monitored through the use of annual surveys to get the views of people who used the service and their relatives. However the service had not sent out an annual survey as the service had been providing care since November 2017. The registered manager showed us a copy of the annual survey and advised they were in the process of sending out to people and relatives in the next few months.

The service worked in partnership with key organisations to support care provision, service development and joined-up care. For example, the registered manager told us they worked with district nurses, social services and the NHS in co-ordinating the care provided to people. Records confirmed this.