Angel Solutions (UK) Ltd

Angel Solutions Community Care

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
Angel Solutions Community Care provides personal care to people living in their own houses, flats and specialist housing. This is a domiciliary care service and primarily provides a service to older people, older people living with dementia, people who may have a physical and/or learning disability. At the time of inspection there were 15 people using the service.

People's experience of using this service and what we found
Risks for people were not identified and recorded in relation to how risks to a person's wellbeing and safety were to be mitigated. Not all people were safeguarded from potential abuse or protected from bullying. Improvements were required relating to the service's recruitment practices and procedures. People were often not informed about staff changes or who may be visiting and sometimes felt the care and support provided was rushed. We could not be assured all people using the service received their medicine at consistent times and improvements were required where amendments to the quantity of medication administered had occurred. Infection control policies and procedures were not as up to date as they should be or in line with government guidance. Lessons were not learned when things went wrong.

The service was not consistently well led and managed, both at provider and service level. Breaches of regulation previously highlighted remained outstanding. The provider and manager had permitted people to receive a care package with the domiciliary care service but without seeking our permission. This was in breach of their conditions of registration. The provider and manager had not acted in an open and transparent way with people using the service by applying the duty of candour.

People were generally complimentary about the care and support provided by staff.

We have made recommendations about safeguarding and abuse, staffing and staff recruitment.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published January 2021).

Why we inspected
We carried out an announced inspection of this service on October 2020. Breaches of legal requirements were found relating to dignity, risk and quality assurance. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions of 'Safe' and 'Well-Led' which contain those requirements.

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 changed from Requires Improvement to 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 Community Care on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to risk management and quality assurance at this inspection.

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.

The overall rating for this service is 'Inadequate' and the service is therefore 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 Community Care

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
The inspection team consisted of one inspector and one assistant inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses, flats and specialist housing.

The service did not have a manager registered with the Care Quality Commission. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or manager would be in the office to support the inspection.

What we did before the inspection
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 asked the provider and manager to send us information relating to their quality assurance arrangements and evidence of staff training. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We conducted the inspection with the manager and administrator. We reviewed a range of records. This included, six people's care files, three staff personnel files and agency staff profiles. We also looked at the service's quality assurance arrangements, the management of medication, staff training and supervision, safeguarding and complaints management.

After the inspection
We spoke with two people who used the service and five people's relatives about their experience of the care provided by the domiciliary care service. We also spoke with two members of staff. We reviewed the service's staff rosters.

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 Requires Improvement. At this inspection this key question has now deteriorated to Inadequate.

This meant people were not safe and were at risk of avoidable harm.

At our last inspection in October 2020, risk assessments were not completed for all areas of risk. This was a breach of Regulation 12 [Safe care and treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We found not enough improvement had been made and this was a continued breach of regulation.

Assessing risk, safety monitoring and management; Using medicines safely
• Although there was no impact for people using the service, the manager was unable to provide assurance and evidence to confirm the health and safety risks for five out of six people had been assessed and recorded. This placed people at potential risk of not having risks to their safety appropriately managed and met.
• Where risks were identified, the information was not robust. Risks were identified during the 'Initial Assessment' process by means of either a mark [tick] or a 'Yes' or 'No'. Where a tick or 'Yes' was recorded, no information was recorded detailing the specific nature of the risk, the impact on the person using the service and the steps required by staff to mitigate this. In addition to placing people at potential risk of not having these appropriately managed, we could not be assured staff had all information required to keep people safe.
• Medicine Administration Records [MAR] were signed by staff to confirm people's medication had been administered. However, though there was no evidence to suggest people using the service required critical medication to be administered at a specific time, not all people received their medication at consistent times. This placed people at risk of receiving their medication too close together and not in line with the prescriber's instructions.
• The MAR for one person showed there were handwritten amendments to the quantity of medication administered. No information was recorded or provided to demonstrate this instruction had been agreed by a healthcare professional, such as GP or pharmacist. This did not provide assurance the person using the service was receiving the correct dose of medication.

Preventing and controlling infection
• The provider's infection control policy and procedure were generic and not specific to a domiciliary care service. The service's COVID-19 policy and procedure did not follow current government guidance.
• The service's infection control audit was last completed in November 2020, despite the COVID-19 pandemic still evident and transmissible within the United Kingdom.
• COVID-19 risk assessments were evident for most staff employed at the service. However, one staff member's risk assessment was signed but had not been completed.

• People told us staff wore face masks, aprons and gloves when providing care and staff confirmed there were enough supplies of Personal Protective Equipment [PPE].
• Staff were routinely tested for COVID-19 in line with government guidance.

This demonstrated a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
• The provider and manager did not have a good understanding of what to do to make sure people were protected from harm or to identify potential abuse. Information viewed demonstrated one person felt bullied by a member of staff. No information was recorded to demonstrate appropriate action had been taken by the provider or manager to investigate the concerns raised or actions taken. We discussed this with the manager, and they confirmed a discussion had been held with the member of staff, but this was not recorded. There was no evidence available to demonstrate discussions had been held with the person using the service. The concerns raised were not referred to the Local Authority as part of safeguarding procedures.

We recommend the provider has a consistent approach in place to safeguard people from abuse and bullying in line with local and national guidelines.

Staffing and recruitment
• Not all call times were for the benefit of people using the service or in line with people's call time preferences. This was confirmed from records viewed and by discussions held with people using the service and those acting on their behalf.
• One person told us their preference was to have their morning calls between 8.00am and 8.30am but recently there had been an occasion whereby staff had arrived at 10.50am. A relative told us their family member could have their morning call anytime between 7.00am and 11.00am, with the lunchtime call anytime between 12.00 midday and 3.00pm and this could be followed closely by their teatime call at 5.00pm. The relative confirmed the person using the service found this very frustrating as they did not want to eat their meals so close together. Neither people nor their relatives were contacted by the domiciliary care office if staff were running late.
• People told us they had not always received consistent care. One relative told us, "Staff come and go so often, at one point we had up to five different members of staff." One person told us staff who supported them could suddenly change without notice and were not made aware of the change until the member of staff arrived at their home.
• The manager told us staff only received their roster on a Friday for the following week. The manager and administrator confirmed an electronic rostering software system had been newly introduced in June 2021. However, neither the manager nor administrator were confident using this system and confirmed they were undertaking ongoing training but were finding this challenging.
• The provider's recruitment practices required improvement. The Disclosure and Barring Service [DBS] certificate for one person was dated June 2019, nine months prior to them commencing in post at Angel Solutions Community Care. There was no information recorded or available to demonstrate the 'Adult First' or 'Update Service' had been checked. The 'Adult First' check is a service that allows an individual to be checked against the adults' barring list. The 'Update Service' check allows organisations to see if any relevant information has been identified about an individual since their DBS certificate was last issued.
• Where recruitment files viewed provided evidence of convictions cited, a risk assessment had not been completed by the provider to assure themselves that the staff member was suitable and safe to work with vulnerable people.
• Information provided by the manager demonstrated five out of six members of staff did not drive. The

service employed drivers by means of an external agency. Profiles from the external agency had been sought and retained. However, one profile provided no details relating to their last or current DBS status. This had not been picked up by the provider or manager.

We recommend the provider ensures staff have time to give people the care and support they need. We recommend recruitment practices are consistent and in line with good practice guidance.

Learning lessons when things go wrong
• When things go wrong, lessons are not learned to support improvement, and this was evident from our findings at this inspection. As already cited within this report, risks were not consistently identified. The provider's arrangements to record and report concerns, and incidents were not effective. Reviews and investigations were not completed.

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. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection in October 2020, the provider had failed to ensure effective arrangements were in place to monitor the quality of the service for people using the service. The provider had failed to ensure people were treated with dignity. This was a breach of Regulation 10 [Dignity and respect], Regulation 17 [Good governance] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We found not enough improvement had been made relating to Regulation 17 [Good governance] and this was a continued breach of regulation. Improvements were still required to ensure people were treated with dignity and respect but this did not meet the threshold to continue a breach of this regulation.

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

- The leadership and overall management of the domiciliary care office did not ensure the service was consistently well-managed or provide assurance people using the service received positive outcomes.
- Lessons were not learned as failings identified had not been addressed by the provider and manager to make the required improvements. The quality assurance and governance arrangements in place were not reliable or effective in identifying shortfalls in the service. The lack of effective oversight and governance of the service has resulted in continued breaches of regulatory requirements, particularly in relation to the management of risk and the service's quality assurance arrangements.
- In April 2021, the provider authorised an external consultant to complete a review of the domiciliary care service in line with the commission's rating system. The subsequent report recorded the outcome as 'Inadequate.' The manager sent us a response to the actions highlighted within the report. However, not all actions as stated had been addressed by the manager and there was a lack of information detailing actions taken to address the identified shortfalls.
- In March 2019, the Care Quality Commission imposed conditions on the provider's registration, to support improvement. This was to stop the provider taking any new people to provide care, while they focused on making the necessary improvements to the service. At this inspection the provider and manager had permitted people to receive a care package with the domiciliary care service but without seeking our permission. This was in breach of their conditions of registration.
- Despite the service having an overall rating of 'Requires Improvement' and the domain of Well-Led being rated 'Inadequate', there was no evidence given our previous concerns that the provider had provided formal supervision to the manager. This was confirmed as accurate by the manager.

• The provider lacked oversight as they failed to ensure the manager's competence relating to their role and responsibilities had been fully checked as part of their recruitment procedures.

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 and manager had not acted in an open and transparent way with people using the service by applying the duty of candour where notifiable incidents had occurred.
• As already cited within the domain of 'Safe', a recent survey completed by one person, recorded them as feeling bullied by a member of staff. An apology had not been provided to the person using the service and there was no information available to demonstrate this incident had been investigated in an open and transparent manner.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People and those acting on their behalf were given the opportunity to provide feedback about the service. A report of the findings was completed as a circular statistical graphic [pie chart] and provided numerical data for the domains of 'Safe', 'Effective', 'Caring', 'Responsive' and 'Well-Led'. However, no information was available to understand people's comments or the context of the findings and how this impacted on the graphic provided.
• Although feedback about the quality of care had been sought, it had not been used to drive improvement. There was lack of evidence to demonstrate feedback recorded had been acted on.

This demonstrated a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff meetings were held to give staff the opportunity to talk about the day-to-day running of the service.