Anjel Direct (Recruitment) Solutions Ltd

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this announced inspection of 'Anjel Direct (Recruitment) Solutions' on 19 October 2018. This was the first inspection for this service since the provider registered with the Care Quality Commission in May 2017.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults and people with physical disabilities in the London Borough of Bexley. At the time of our inspection there were eight people using the service.

People told us that their care workers arrived on time and were reliable. The provider did not consistently use safer recruitment processes to ensure that staff were suitable for their roles. Care workers were aware of their responsibilities to safeguard people from abuse.

There were processes for assessing and managing risks to people using the service, but these were not effective in managing the risk of pressure sores. Where people were supported with their medicines, care plans and logs of care were not consistent on the level of support people required. There was insufficient recording of what medicines people had been supported to take and when, and there were not effective audits carried out of this.

Care workers received induction and training. Care workers did not always receive the mandatory training. Some, but not all, mandatory trainings were booked to take place. Care workers told us that managers checked that they provided a good service, but there were not records maintained of this. Managers did not keep records of the formal supervision of care workers.

People had not signed their care plans to indicate consent to care. Where people were not able to consent to care there were not measures in place to assess people's decision making capacity and to evidence that care was provided in their best interests.

People's care needs were assessed in detail. This was used to plan people's care in order to meet these. Care plans were person centred and contained information on people's preferences for their care. There was information on how best to communicate with people and what may cause people to become anxious and upset. Plans captured people's health care needs and how they impacted on their wellbeing and daily living skills. Records of care were brief and frequently incomplete and did not demonstrate that people received care in line with their plans. Managers did not have audit systems in place which would allow record keeping to improve.

People told us that they received support which was flexible and met their needs. People consistently received care from the same care workers and knew how to complain if something needed to improve.

We found breaches of regulations relating to safe care and treatment, the management of medicines, staff

recruitment, training and supervision, consent to care and good governance. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks assessments were carried out but were not always in place to address sufficient risks.

People told us that care workers arrived on time but the provider did not always follow safer recruitment processes. People felt safe with their care workers and staff understood their responsibilities to report suspected abuse.

Record keeping was not sufficient to ensure the proper and safe management of medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

There were appropriate assessments of people's support needs, including those relating to nutritional and healthcare needs.

Care workers did not always receive mandatory training and the provider did not keep records of supervision and observations of practice.

The provider did not obtain consent to care or work in line with the Mental Capacity Act (2005) when people were not able to consent.

Is the service caring?

Good

The service was caring.

People told us their care workers were friendly and caring.

People received support from a consistent staff team. People told us they were treated with dignity and their independence was promoted.

Care plans had information on how to communicate with people and what could worry or upset them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People told us they received the care they needed and that care workers were flexible.

People's care plans met their needs, but recording of the care people received was poor and frequently did not show how care was delivered as needed.

Complaints were responded to and investigated and people knew how to make a complaint if they needed to.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Care workers told us they felt well supported by the registered manager and had regular checks of the quality of the service they provided. There were no formal records maintained of these.

Records of care provided were of a low quality and were often incomplete. There were not systems of audit to monitor and address these.

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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.

Why we inspected- this was a routine first ratings inspection. We aim to inspect services within 12 months of registering with the Care Quality Commission. We were unable to inspect as planned in May 2017 as the provider informed us that they were not carrying out a regulated activity. We scheduled this inspection when the provider informed us they were no longer dormant. We were not aware of any allegations of a safeguarding nature regarding this provider.

This inspection took place on 19 October 2018. We gave the provider four days' notice of this inspection. This is because it is a small service and the registered manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in. The inspection was carried out by one adult social care inspector.

Prior to this inspection we reviewed records we held about the service, such as notifications of serious events the provider is required to tell us about by law and information from third parties about their experiences using the service.

We looked at records of training and recruitment of four care workers and records of care and support for four people who used the service. We spoke with the registered manager, a quality assurance manager and two care workers. We made calls to one person who used the service and three relatives of people who used the service and spoke with a commissioning manager and invoicing officer with the local authority.

Requires Improvement

Is the service safe?

Our findings

People were not always protected from risks to their wellbeing. The provider carried out generic risk assessments in key areas. These included risks relating to people's living environments. There were moving and handling plans in place which assessed whether people required support to mobilise, the safety of any equipment which was in place for people and the number of care workers required to make transfers safely. One person was regularly hoisted in and out of bed, but the provider had not verified that the hoist had an in date check to ensure that it was safe to use.

Two people were considered at high risk of developing pressure sores, but the provider had not carried out an assessment of the risk to these two people or recorded the measures in place to mitigate these. The provider told us one person needed repositioning on each visit, but this did not form part of the care plan. Daily records showed that the person was repositioned on some but not all visits and there were no repositioning charts in place which would allow this to be more easily checked. Another person had recently developed a pressure sore; there was evidence that this was noted by care workers. However, when this had initially been noted the person's relative was asked to contact a district nurse, which resulted in a delay seeking medical advice. The care worker later did this on the person's behalf. There was no plan in place for preventing a recurrence or worsening of the condition.

The provider had an incident book for recording when adverse events had taken place; there had only been one incident of concern since the service had begun. The provider had recorded the nature of the concern and the actions they had taken. This referred to when a person's pressure ulcer had worsened. Although the provider had taken action to ensure that immediate actions were taken, they had not carried out a risk assessment to mitigate this risk in future.

The provider told us they were supporting two people to take their medicines. This took the form of prompting people when it was time to take their medicines.

Plans were often inconsistent about the level of support people required with their medicines. For example, one person's care plan stated their next of kin managed their medicines, however the visit plan stated that the person was to be assisted with medicines on each visit, although daily records of care showed that care workers did not provide this support.

There was not sufficient record keeping of what support people received with the medicines. One person's visit plan stated that they were to be prompted and assisted with medicines; however the visit record showed that this was only recorded by care workers twice in a one week period. For another person their care plan stated they were to be prompted to take their medicines. This was consistently referred to on daily notes, however care workers usually stated that they had 'given' the person their medicines. The provider did not use medicines administration recording (MAR) charts to record the support people received with medicines, and it was not recorded what medicines people had been prompted or otherwise assisted to take.

We asked the provider to read the National Institute for Health and Care Excellence (NICE) guidelines "Managing medicines for adults receiving social care in the community" to ensure that they managed medicines safely following best practice guidelines.

The issues in the seven paragraphs above represented a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not always follow safer recruitment practices. Before care workers started, the provider obtained proof of people's identity and address, full work histories and verified that people had the right to work in the UK. Of the four care workers' files we looked at, the provider had carried out checks of two staff with the Disclosure and Barring Service (DBS). The DBS provides information on people's background, including convictions, to help employers make safer recruitment decisions. For another two workers, the provider had obtained copies of checks from previous employers. Although these did not highlight any issues of concern, both of these checks were over a year old, and the provider had not checked whether there had been any changes to staff's statuses since this time.

The provider had obtained references for each care worker. However, providers are required by law to obtain evidence of satisfactory conduct in previous health or social care employment. They had not fulfilled this requirement as one person's work history showed previous employment in social care which had not been covered by references, but had a reference for employment outside this field. For another person, there was a personal reference and one professional reference, but the provider had not obtained a reference for a four year period working in healthcare.

This was a breach of a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In one instance a person required two care workers on each visit, however staff did not maintain sufficient records of daily visits which could verify that two care workers had always attended.

Care workers had received training in safeguarding adults. Care workers we spoke with were confident in recognising and reporting the signs of possible abuse and were confident that these would be taken seriously by managers. A care worker told us "These are people you see every time, the day you go in and the person is withdrawn you know something is not right". The provider were aware of who to contact in the event of a safeguarding issue and how to trigger an investigation.

Requires Improvement

Is the service effective?

Our findings

As part of the recruitment process, the provider assessed the knowledge and skills of prospective care workers. This included carrying out written tests of people's knowledge in key areas such as infection control, continence management, safeguarding adults, confidentiality and privacy and dignity. The provider also obtained evidence of training courses people had undertaken elsewhere. There was an induction process in place outlining the areas that should be covered, but this was not completed for all care workers. Comments from care workers included, "They did a full induction for me… I did shadowing. He takes you there and explains everything to you, this enables me to do my job very well."

The provider had a list of mandatory training that all care workers should receive. All care workers had received training in moving and handling and safeguarding adults. There were dates for care workers to receive training in communication and mental capacity training with the local authority. However, care workers had not received training in medicines or food safety and only two had completed first aid training. One had not received health and safety training. Comments from care workers included "We do a lot of training" and "They send you to go and do the training."

The provider told us that they regularly supervised care workers in people's homes to ensure they were carrying out their roles competently, and we confirmed this by speaking with care workers. However, there were not records kept of any formal supervision or observation of care workers.

This was a breach of a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was not obtaining consent to care in line with the Mental Capacity Act 2005 (MCA). The Act 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 majority of people using the service were able to consent to their care; however nobody had signed their care plan to indicate their agreement. Where a person was non-verbal and unlikely to be able to consent to their care, the provider had not carried out an assessment of their capacity and was not following a best interests process in line with the requirements of the Act.

This was a breach of a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of the care planning process, the provider assessed people's needs in a number of key areas, including those relating to personal care, nutrition, mobility, continence and communication. Assessments included whether a people experienced symptoms from health conditions, and rated these on a scale from 'absent' to 'severe and uncontrollable'. The provider assessed what people could do for themselves and areas of care and support which were provided by family members. Care plans contained a summary of

people's medical histories, including how conditions such as dementia or arthritis impacted on people's daily living needs.

The provider assessed people's nutritional needs. At the time of our inspection there was nobody who needed nutritional support. Care plans highlighted when people may need their food cut up or support preparing and serving meals. Care workers recorded when people had been given food in line with their plans, but lacked detail on what people had eaten and whether they had been supported to maintain hydration.

Good

Is the service caring?

Our findings

People told us that the service was caring. Comments from people included "They were good as gold and friendly" and "They are carers, they care. As long as you know they care that's it. They're never doing anything that's a nuisance."

People's plans included information on how best to communicate with people and what may cause people to become upset or distraught. There was information on some topics or actions which may worry a person or upset them, such as family issues, being unable to do things for themselves or being spoken over. A family member told us "[My relative] doesn't know the carer well enough to have a quality conversation with them, but it's not for their want of trying."

As part of the provider's assessment they identified key information relevant to providing person centred care. This included things the person would like the care workers to know about them, their hobbies and interests and how they liked to spend the day. There was information on plans about when people preferred to get up early, and evidence that people had chosen the time of their visit to suit their preferences.

Records of care showed that people received care from consistent care workers, and in many cases, it was a single care worker providing care to a person throughout the week. A person told us "It's been the same [carer] as well, which has been quite nice."

People's plans identified people's religious beliefs and any support that people may need to practice their religion, but nobody using the service required support to access places of worship. Care plans were also clear for care workers when people chose to, and not to, discuss religion, and that where relevant conversations about religion should only be initiated by the person.

People who used the service told us that they were able to do things for themselves. One person told us, "I like to do a lot myself while I can" and another person said, "It works the way I want it to work." Care workers gave us examples of how they promoted people's independence and respected their dignity. One care worker said, "I encourage people to do it themselves, it's their dignity as they would love to do it themselves."

Care workers had a good understanding of how to promote confidentiality. This included not sharing information with third parties or discussing other people's private matters with people using the service. Both care workers volunteered this as examples of how they promoted people's privacy.

Requires Improvement

Is the service responsive?

Our findings

The provider worked with people to compile a care profile. This covered key areas of daily living skills and outlined people's abilities and their desired outcomes from their care, and the support people required to meet this. This included details on how people received personal care, the support they required to mobilise, eat and drink and maintain their home. This information was used to compile a brief care plan for care workers to follow, which gave key information on how to access people's houses, people's preferences for their care such as when they liked to get up and receive care, and the tasks that care workers needed to do on each visit.

However, recording of daily visits did not contain sufficient information to be certain that tasks had been carried out. For example one person's visit plan stated that they were to be supported to change their pad on each visit, but the record of care made reference to this once in 21 visits. Another person also needed support to change their pad on each visit but care workers had referred to this three times in 12 visits.

Care plans stated that care was to be reviewed every six months, but at the time of our inspection nobody had been using the service for this period of time. People told us that their care was responsive and flexible. Comments included "It's all pretty flexible" and "[my carer] does what I want her to do."

Care workers told us that information on care plans was usually accurate and helpful. Comments included "The care plans are useful, that's where you get to know who they are and what to do for them. Most of the time it is correct" and "They give you the care plan so you can read it up."

When people had complained about the quality of the service the provider had worked with the local authority to investigate and respond to complaints. People received a service handbook. This included information on how people could make complaints about their care and the timescales in which complaints should be addressed. People told us they knew how to make complaints. Comments included "To be honest I haven't needed to but I've got all their contact numbers" and "I've got no complaints at the moment at all."

Requires Improvement

Is the service well-led?

Our findings

The provider did not always obtain a complete record of what care people had received. The format for daily recording involved recording an entire week's visits on a single page. This meant that when people received more than one visit a day care workers were writing in a very small space. Daily logs did not contain the times care workers had attended or any detail on how a person was and exactly what support they received. Sometimes several visits were recorded on an entire line and some visits were not recorded at all.

There were no formal systems in place for auditing logs of care or medicines to ensure that these provided a contemporaneous record of how the person's care plan was followed.

This was a breach of a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had timesheets which indicated when people were visited, however these were pre-printed and did not take account of how visits may vary each day, and were not signed by people to confirm they had received their visits. The provider told us that they raised invoices for each person's support, and we confirmed with the local authority that these were correctly completed and signed by the person to ensure that they had received their support hours.

Staff told us they felt well supported by their manager. A care worker told us "I've worked with previous agencies, sometimes when you tell them you don't want to work that way they are bugging you. With Anjel Direct they just say Okay." Another care worker said "[The registered manager] is very committed, he works as a carer in the field and works with us most of the time." Care workers who did not drive told us that the provider arranged to transport them between people's homes in order to arrive on time. The registered manager told us "I've had to reskill myself. In the past I used to sit in the office, now I am out in the field and have a discussion with people."

Care workers told us that the registered manager carried out checks of their care. Comments included, "When he comes he checks what we're doing, we're not expecting him. He checks the book and the time we came and to check what we are doing, to check if we are using the equipment rightly" and "He comes in with you to see if you are doing the job very well." However, the provider did not keep records of these checks.

There were regular meetings held with the office staff in order to monitor quality issues. This included preparing for quality assessment visits from the local authority, responding to complaints and to ensure that staff were aware of policies. Meetings of office staff were also used to discuss contract and recruitment issues. The provider told us "We're still small and we intend to put in the effort to…expand."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not provided with the consent of the relevant person. The provider did not act in accordance with the 2005 Act 11(1)(3)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users as the registered person did do all that was reasonable practicable to mitigate risks to the health and safety of service users of receiving the care and treatment or ensure the proper and safe management of medicines 12(1)(2)(b)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established or operated effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity or maintain securely an accurate, complete and contemporaneous record in respect of the care and treatment provided to the service user 17(1)(2)(a)(c)

Regulated activity	Regulation

Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment processes were not established or operated effectively to ensure persons employed for the purpose of carrying on a regulated activity were of good character as information was not available as specified in Schedule 3 of this regulation 19(2)(a)3(a)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Persons employed by the service provider in the provision of a regulated activity did not receive such appropriate training and supervision as was necessary to enable them to carry out the duties they were employed to perform 18(2)(a)