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# The Angels on Call

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

| | |
|---|---|
| Is the service safe? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

About the service
The Angels on Call is a care service providing personal care to people in their own homes. At the time of the inspection 16 people were being supported.

People's experience of using this service and what we found
People were not always supported safely when staff administered medicines. For one person, the processes in place for medicine administration were not robust and did not allow staff to effectively check the medicines they were administering. This was addressed by the provider following our inspection.

There had been improvements in the way the majority of people's medicines were managed since our last inspection.

The risks to people's safety had been assessed and measures were in place to safely support them. There were improved processes to ensure people were protected from possible financial abuse and staff had received safeguarding adults training.

There were enough adequately trained staff to support people and the recruitment processes had improved, so people were supported by suitable people.

People were protected from the risks of infection as the provider had followed national guidance about the management of COVID - 19, ensuring staff were following best infection prevention and control practices.

There had been improved oversight of the service and the provider had over the last six months introduced a more robust quality monitoring process. They had employed an administrator to support them with the quality monitoring processes. These processes need time to embed in the service, to ensure the care people receive remains at a good standard.

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 Inadequate (published 18 May 2021) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

This service has been in Special Measures since 18 May 2021. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
We carried out an announced focused inspection of this service previously on 30 March and 7 April 2021. Breaches of legal requirements were found. This included safe care and treatment, governance, safe recruitment of staff and reliability and trustworthiness of the registered person (provider). 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 Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions were not looked at on this occasion however were used in calculating the overall rating at this inspection. The overall rating for the service has changed from Inadequate to Requires Improvement. 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 The Angels on call 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 monitor the service.

We have identified breaches in relation to safe care and treatment related to safe medicines administration.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

## 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.

Details are in our safe findings below.

**Is the service well-led?**

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

# The Angels on Call

**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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by two inspectors and an Expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service

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

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
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 registered manager would be in the office to support the inspection.

Inspection activity started on 7 December 2021 and ended on 14 December 2021. We visited the office location on 9 December 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service. 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 took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service and seven relatives about their experience of the care provided. We spoke with four members of staff including the provider, and care workers.

We reviewed a range of records. This included three people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Requires Improvement

# Is the service safe?

## Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to requires improvement. This meant while there had been improvements of the service, some aspects of the service were not always safe. There was a risk that people could be harmed.

At our last two inspections the provider had failed to properly assess and manage a range of potential risks to people's safety. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The concerns related to management of infection prevention and control (IPC) and management of medicines.

Although there was significant improvement in the provision of safe care and treatment, this related to IPC practices and the overall management medicines.

However, the provider was still in breach of this regulation as we found some concerns around the administration and management of a person's medicines.

Using medicines safely

- At our last inspection the provider had not undertaken consistent audits to ensure the safe management of medicines and two staff who were administering medicines had not received training in the safe handling of medicines. At this inspection we found all staff who supported people with their medicines had received appropriate training.
- Although we saw the medicines auditing processes had improved, we found an area of concern around a person who had the support of their family to take their medicines, when family members were not available, staff supported them. The processes in place around this practice were not robust and did not allow staff to effectively check the medicines they were administering. This put the person at risk of receiving their medicines in an unsafe way.

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

Following our inspection, the provider immediately reviewed and changed staff practices to ensure staff administered the medicines safely.

Preventing and controlling infection

- At our last inspection we found the provider did not have robust processes in place to protect people from the spread of infection including COVID - 19. They were not following government guidance to ensure staff were regularly tested and not all staff had been vaccinated. At this inspection we saw evidence to show staff were complying with the regular COVID - 19 testing regime. Staff supporting people had also taken part in the government's vaccination programme.

● People told us staff always followed good IPC practices when providing support for them. One person said, "They do (wear masks, gloves and aprons) and also sanitise (their hands)". We were assured that the provider had made enough improvement to reduce the risk of the spread of infection and the service was no longer in breach of this part of the regulation.

Staffing and recruitment
At our last inspection the provider was in continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. At this inspection we found the recruitment processes had improved and the provider had a better understanding of her role in using safe recruitment processes.

The provider was no longer in breach of this regulation.

● We viewed two staff files and saw the provider had used the disclosure and barring service (DBS) to check if potential staff had any criminal convictions. The use of this service helps employers protect vulnerable people from potentially unsuitable staff.
● People were supported by adequate numbers of staff who had received training to support them in their roles. People told us staff were usually on time or if they had been held up at a previous call, they would always let the person know. People were complimentary about staff; we were told people were supported by a consistent small number of staff and the provider either helped with their support or visited regularly to ensure staff were providing good care.

Systems and processes to safeguard people from the risk of abuse
● At our last inspection people were not always supported by staff who had received training to support their knowledge of protecting people from abuse. At this inspection we found staff had received training. One member of staff told us it was one of the first training modules they undertook when starting at the service. The provider undertook quizzes and use supervision to test staff knowledge and when we spoke with staff, they were aware of their responsibilities around safeguarding people in their care.
● The provider had also reviewed practices around handling of people's monies in areas such as personal shopping. When required there were clear records to show itemised receipts to account for any monies spent on a person's behalf. People we spoke with trusted the provider and staff. They felt staff were careful about security at their home and they felt safe with the individual security arrangements in place.

Assessing risk, safety monitoring and management
● The risks to people's safety had been assessed and measures were in place to reduce the risks to people's safety. A couple of records needed some aspects of care clarifying. For example, one record gave conflicting information on moving and handling techniques. However, our conversations with staff and the person showed they were being supported in line with best practice and following our visit the provider amended the person's care plan to better reflect the support they received.

Learning lessons when things go wrong
● The provider had processes in place to learn from events. We saw minutes of meetings where people's care had been discussed, staff used a secure messaging system to keep each other up to date with any changes to people's care. The provider also used staff supervisions to discuss any events and how things could be improved.

Requires Improvement

# 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 now improved to requires improvement. This meant although improvements had been made, further improvement were required to ensure the service management and leadership was inconsistent.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

At our last two inspections the registered person (provider) had failed to demonstrate their good character in the carrying on of the regulated activity. This was a breach of Regulation 4 (Requirements where the service provider is an individual or partnership) of the Care Quality Commission (Registration) Regulations 2009. There were inconsistences in what the registered person (provider) had told us about aspects of the service and what we found.

At this inspection there had been improvements in the provider responses to our concerns and they were no longer in breach of this regulation.

● At this inspection the information we were given by the provider in their monthly action plan reports sent to us was in line with the evidence found on the day of inspection. For example, staff training records matched what the provider told us about the work they and staff had put in to keep staff training up to date. Staff supervision and recruitment processes were robust.
● Where required and as part of the provider's legal responsibility we had been informed of events at the service via our statutory notification process.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last two inspections the provider had failed to assess and monitor the quality of the service and take action to address a wide range of potential risks to people's safety and well-being. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection the provider had made improvements to their governance processes, and although further minor improvements were required, along with further embedding of processes, they were no longer in breach of this regulation.

● The provider showed a better oversight of the running of the service and had employed an administrator to support them keep up to date with the quality monitoring processes. This had resulted in up to date

information for staff in care plans, better oversight of monitoring of people's finances, staff training updates and calls monitoring.

● However, the administrator was still completing training to support them in their role. The provider told us the administrator was very keen to fulfil their training and had showed a good understanding of their role.

● Whilst we saw the medicines audits had been completed, the issue we have reported in our safe section had not been highlighted by the provider audits. The provider addressed this following our inspection.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics.

● Both people and staff we spoke with told us the provider worked in a person-centred way. People told us they usually had a small group of key staff who supported them and worked in the way they wanted. One person gave an example of how the provider had worked with them to provide their personal care in the way they wanted it.

● People's care records reflected their personal choices around their care and people told us the provider was consistent in their approach to their care. One relative said, "Excellent. The standard of care has remained the same.  Personal and friendly."

● People were asked their opinions of the service they received; several people told us they had completed questionnaires from the provider about the standard of care. People told us the provider was visible and approachable, they felt they could raise concerns to her. One person said, "She (provider) does visit and I often speak to her on the phone."

● Staff told us they felt well supported by the provider. New staff had undertaken an induction and received training for their roles when they started work for the Angels on Call. One staff member said, "(I have) been in care 20 years, first time I have done house calls. I enjoy it very much and I could not ask for better (support)."

● People confirmed when new staff visited them, the new staff member was supported by a carer who knew them well to ensure care was consistent.

Continuous learning and improving care; Working in partnership with others

● We saw evidence of staff working with families to ensure people's health needs were managed. Families told us they managed people's appointments but there was good communication from staff if people needed support.

● The provider and staff had worked consistently since our last inspection to improve their knowledge and skills, so people were provided with good care. We discussed that this improvement needs time to embed in the service so future care remains consistent.

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 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Medicines were not always managed safely. |