Review of compliance

Mrs Sita Kumar t/a Angels Community Homecare Services Halesowen Angels Community Homecare Services	
Region:	West Midlands
Location address:	83 Long Lane Halesowen West Midlands B62 9DJ
Type of service:	Domiciliary care service
Date of Publication:	March 2012
Overview of the service:	Angels Community Homecare Services provide personal care for people in their own homes.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Angels Community Homecare Services was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review to check whether Angels Community Homecare Services had made improvements in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

We spoke to four people who use the service, two relatives, and three staff.

People and their relatives told us they felt comfortable approaching the manager with any concerns. One relative told us, "Since the manager started some stability has been achieved and things have improved."

People told us they were happy with the care that was provided. One person said, "They have treated me like my own daughter would."

People told us that the senior care staff sometimes went to observe the care staff at work. One person said, "The senior carer came just yesterday." This means that senior care staff are monitoring the quality of care.

What we found about the standards we reviewed and how well Angels Community Homecare Services was meeting them

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

People received care that supported their needs and rights.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Systems need improvement to ensure that all aspects of the service are monitored, analysed, and improved.

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

Systems are not in place to ensure that records are accurate and can be located promptly when required.

Actions we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found
for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
People told us they are involved in planning their care and agreeing call times. People told us that staff treated them with respect and three people told us staff were "very good." Staff were able to describe how they maintained people's dignity. One person told us, "I would not like to be without them now."

Some people and their relatives told us that there are always different care staff and one relative said, "It would be much better if there were a stable set of carers." One person told us they had complained about this to the manager as they had different care staff and some that they "could not get on with at all." This means that people cannot be confident that they are supported by people who know them well.

People and their relatives told us staff were generally on time. One person told us "they phone straight away if there is a change." This means people felt comfortable and assured that care staff will keep them well informed of any changes.

We saw that some care plans had not been updated to reflect changes in individuals care needs. The staff told us they were told about these changes every Monday morning when they went to the office to collect their weekly rotas. Staff also told us this was an opportunity for them to discuss people's care needs. This means that staff were given updated information about the changes in people's care needs.

There was some information in the daily log where people had incidents, but there was no information stating what actions care staff had taken. For example, staff had

recorded that one person was dizzy and confused but there was no information about what the staff member did about this. This was raised with the manager, who told us that the family was contacted following this incident but that this outcome was not recorded.

Other evidence
There is no further evidence.

Our judgement
People received care that supported their needs and rights.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
Most people told us that they felt confident approaching the manager with any complaints. One person told us, "Things have improved after having a clear designated manager."

We saw a complaints log, which showed that five complaints made since 2010 were investigated. Although there was no written analysis of these complaints, discussions about the themes took place during staff meetings. We saw that some complaints people and their relatives told us about were not in the complaints book. One person told us, "I raised the complaint, put it in writing but got no response and that was 12 months ago." This means that not all complaints were responded to and taken seriously.

Staff meetings had taken place intermittently throughout the year. Some issues raised included care staff completing documents at the beginning of the visit instead of at the end and staff going to home visits at their own times. This means that management identified some issues and attempted to resolve them.

We saw people and their relatives were sent surveys in April 2011 to comment on the quality of service. We saw that the information was collected and summarised. However, there was no action plan with this to show what changes will take place as a result of the findings. This means that although people's opinions are sought these may not be taken seriously.

We saw an accident book, which recorded accidents or incidents that took place. There was no analysis of this information to identify patterns and trends. This means the home does not identify shortfalls to make any changes or improvements to minimise risks.

Staff told us senior care staff audit different aspects of their performance including timeliness, quality of care, maintaining dignity and duration of the call. There is a central place for recording this and several changes have been made after analysing the results. For example the amount of travel time staff had from getting from one person to another has been increased as it was found that the target was unrealistic meaning staff would usually be late. This means there is a process of monitoring and implementing positive changes for people and staff.

Other evidence
There is no further evidence.

Our judgement
Systems need improvement to ensure that all aspects of the service are monitored, analysed, and improved.

Outcome 21:
Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:
* Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
* Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

There are moderate concerns with Outcome 21: Records

Our findings

What people who use the service experienced and told us
There is no other evidence.

Other evidence
Records detailing care were not always completed, clear, accurate or systematically stored. One person's care records were missing since June 2011. The manager told us the remaining notes would be at the person's house and must not have been collected monthly, as it should have been. This means that notes are not stored securely and that staff may not always have all the information they need.

We saw that people's daily record entries were either not dated or were not legible. The records were not in consecutive order and it was difficult to understand which entries were recent and which were entries from previous years. This means that peoples care records were not always understandable or stored in a way that would be easy to access.

We looked at medication records which should record what medication was administered and when. Two separate sheets were used to record what medication people were administered. There was some information of the person's daily record and a separate medications sheet to complete. There were discrepancies between both sources of information. This means that there was inaccurate recording of medicines administered to people.

Staff described a management system that was agreed and used in relation to daily records. The archiving and filing of the records did not take place as was arranged. This means that there were no systems to identify shortfalls with the system being used and the quality of records.

Our judgement
Systems are not in place to ensure that records are accurate and can be located promptly when required.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	Why we have concerns: Systems need improvement to ensure that all aspects of the service are monitored, analysed, and improved.	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 28 days of the date that the final review of compliance report is sent to them.

CQC should be informed in writing when these improvement actions are complete.

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: Systems are not in place to ensure that records are accurate and can be located promptly when required.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 28 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
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