Universal Care Services (UK) Limited

Universal Care Services Coleshill

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 7 September 2017.

Universal Care Services Coleshill provides domiciliary care to people in their own homes. At the time of our inspection, 187 people were supported with care.

The service did not have a registered manager. 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 2008 and associated Regulations about how the service is run. A new manager had been recruited, and the provider assured us an application to 'register' the manager with CQC would be made as soon as possible.

The service was last inspected on 28 April 2016, when we found the provider was compliant with the fundamental standards described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the last inspection the service was rated 'good' overall. At this inspection we found improvements were required.

People were not supported by consistent staff, experienced missed care calls, and care calls that did not take place at the times agreed in their care plans. They also received calls that were reduced in length and did not ensure their needs were met.

People did not always have their medicines administered safely and as prescribed. There were gaps in medicine administration, and mechanisms in place to record and audit when medicines were given were not effective which put people at risk.

People and their relatives told us they felt safe with the regular staff who supported them. Staff received training to safeguard people from abuse and understood what action they should take in order to protect people from abuse. However, staff did not always feel supported by the provider, and were not confident action would be taken if they reported concerns.

Risks to people's safety were identified but risk assessments did not always give staff who were unfamiliar with the people they supported, enough information to ensure risks were managed consistently.

People told us staff asked their consent before undertaking any care tasks. Where people were able to make their own decisions, staff respected their right to do so. People's care records included some information on the support they needed with decision making. Staff and the management team did not always have a good understanding of the Mental Capacity Act (2005).

Newly recruited staff did not always receive an effective induction to the service, and we could not be

assured that either new or experienced staff had their competence and skills checked by the provider to ensure they remained effective in their roles. Staff had not had the opportunity to attend individual meetings to discuss their work since the previous manager left in May 2017.

People and relatives told us their regular care workers were respectful and treated people with dignity, kindness and respect. However, they told us the provider and office staff did not always respond to them in respectful, caring ways and that communication was not effective. People did not always receive care that was in line with their choices. People's privacy was maintained.

People's care records were not always up to date and did not always give staff key information they needed to respond to people's needs consistently.

People and relatives told us they felt concerns raised by them were not taken seriously and not dealt with effectively. Complaints records kept by the provider did not reflect the nature or volume of complaints and concerns received.

Systems which checked the quality of the service provided to help it improve were not being used. The provider did not ensure staff had the opportunity to meet to share good practice, and did not ensure staff performance was assessed regularly to check they remained competent in their roles.

People, relatives and staff were not supported by the management team, and did not feel the service was well managed or effective.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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?

Inadequate

The service was not safe.

People's support did not always take place as planned or at all and were not always supported by a consistent and regular group of care staff. There were insufficient numbers of care staff, and staff were not appropriately deployed to keep people safe. People did not always receive their medicines safely or as prescribed. Systems to check medicines were given safely were not used and records intended to demonstrate accurate administration of medicines were not always completed. People's needs had been assessed and risks to their safety were identified. However, risk assessment did not always give staff the information they needed to manage risks consistently. Staff were aware of safeguarding procedures and knew what action to take if they suspected abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

New staff were not always inducted effectively into the service. Checks designed to ensure new and existing staff were working in line with the provider's expectations were not in place. People were able to make their own decisions, and were supported by staff who respected and upheld their right to do so. Staff had a limited knowledge and understanding of MCA and DoLS legislation. However, staff knew how to manage this and supported people with decision-making appropriately. People received timely support from health care professionals when needed to assist them in maintaining their health.

Is the service caring?

Requires Improvement

The service was not always caring.

People and relatives told us the provider and office staff did not treat them with kindness, dignity and respect, and that the service people received was not in line with their choices and preferences. They told us this did not promote people's well-being.
People told us they were supported with kindness, dignity and

respect by regular care workers. Most staff were patient and attentive to people's individual needs and had a good knowledge and understanding of people's likes, dislikes and preferences. People were supported to be as independent as possible by staff who showed respect for people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care records were not personalised and had not always been updated to include information staff needed to respond to people's needs consistently. People knew how to raise complaints but these were not always recorded or responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There were quality monitoring systems in place to identify any areas needing improvement, but these were not used. The provider had failed to take action to improve the service people received, and had not made plans to mitigate known risks, or to reduce the risk of events occurring where these were known. People, relatives and staff did not have confidence in the management or quality of the service, which they said had deteriorated significantly over the past four months.

Universal Care Services Coleshill

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.

The inspection took place on 7 September 2017 and was announced. We told the provider of our visit 48 hours in advance so they had time to arrange for us to speak with staff. The inspection was conducted by two inspectors. We brought the planned inspection forwards due to concerns we had received from members of the public and staff members.

We reviewed the information we held about the service. We looked at information received from local authority commissioners. Commissioners are people who find appropriate care and support services for people, and fund the care provided. We also looked at concerns we had received by members of the public. We also looked at statutory notifications sent to us by the service. A statutory notification is information about important events which the provider is required to send to us by law.

We did not ask for a provider's information return (PIR). This is a form we ask providers to send to us before we visit. However, during our inspection visit, we gave the provider the opportunity to give some key information about the service, what the service does well and improvements they planned to make.

During our inspection visit, we spoke with the nominated individual, the regional manager, a recruitment manager, a care co-ordinator and three care workers. A nominated individual is the person designated by the provider as being responsible for oversight of the service. Following our inspection visit, we spoke by telephone with twelve people, four relatives, three care workers and a newly appointed clinical lead.

We reviewed eleven people's care plans, to see how their care and support was planned and delivered. We

looked at other records related to people's care, and how the service operated to check how the provider gathered information to improve the service. This included medicine records, staff recruitment records, the provider's quality assurance audits and records of complaints.

Inadequate

Is the service safe?

Our findings

At our last inspection we rated 'safe' as 'good'. At this inspection we found people were not safe, and that significant improvements were required to keep people safe.

Current staffing levels did not ensure people received consistently safe care. The provider had recently been awarded a contract by the local authority in April 2017 to provide care for a larger number of people. Since the contract had been awarded, people told us the service to them had changed for the worse. One person told us, "The service has been awful in the last few months. They [care workers] are supposed to get to me between 7:30am and 8am in the morning, but they weren't getting to me until 10 a.m. One morning, I had to crawl to the toilet and sat in my own urine for twenty minutes. Another person said, "When the usual care worker was on holiday it was horrendous. They either couldn't come at all some days or were coming at lunch time to get my husband out of bed. It meant I had to do it. All this has meant hospital appointments have been missed as we have not been ready in time."

One relative told us their relation should have a 45 minute call. They told us staff often rushed the call which made their relation feel ill. They explained that on one occasion two care workers were sent out instead of the usual one so the call time could be reduced to 20 minutes. The care workers kept saying 'hurry up, hurry up'. The result of this was their relation was very breathless and had chest pain.

Another relative told us, "Universal have far too much work and haven't got the carers to cover it. It's been like this for three or four months and it's just getting worse." Other relatives also commented on calls being missed, with one saying, "On one occasion recently the carer did not come until 3:45 in the afternoon, so [name] was in their incontinence pad since the night before."

A staff member told us, "For the last three or four months it's been a nightmare. Since we took on the new contract, all of a sudden there are lots of problems. We just can't cover everything." Another staff member said they had been told by the office to 'short call' (reduce the agreed amount spent at a visit) to enable them to cover additional calls. They added, "I've refused."

Rotas confirmed staff had been allocated additional calls which could not be completed in the time available, and for the length of time agreed. For example, one staff member had availability to take on extra calls between 9.45 am and 11 am. We saw the staff member had been allocated four additional 30 minute calls. Another staff member had been allocated an additional 53 care calls in one week during August 2017.

Staff told us how staffing levels impacted on people. For example, one person had told staff their mental health and consequently their safety had been affected by the lack of consistency of their care calls.

Another person was dependent upon staff to provide them with meals and their medicine. This was an important part of managing a specific medical condition. A 'quality monitoring form' the provider used to capture people's views on their care, dated 5 September 2017 recorded how the person had contacted the police because they had been unable to get a response from the office staff to inform them no one had

arrived to provide their care call. Records showed the care call was provided at 23.55, but should have been much earlier. This meant the person was anxious and distressed, and police officers had to attend to reassure the person. We spoke with the nominated individual who told us they had no knowledge of the incident.

When we asked staff if care calls had been missed they confirmed they had. One staff member said, "Yes, calls are missed. Me and the other carers worry about our clients. So we communicate with each other try to make sure everyone [people] is covered. It's a real worry." Staff told us since the registered manager left the service in May 2017, 'staff rotas' had not been planned in advance which staff felt was the reason for the missed calls. The nominated individual acknowledged some people had not received their planned calls. They told us, "It has been a really difficult time but we are addressing this."

The provider acknowledged they needed to recruit more care workers to ensure people received consistent support. They told us three care staff started during the week of our inspection visit, and a further four care staff were currently undertaking their initial training and would begin their induction the following week.

This was a breach of Regulation 18 (1) HSCA (RA) Regulations 2014 Staffing.

Medicines were not always managed and administered safely. One person told us their 8.30am calls sometimes happened at 11am. This meant they did not receive their tablets on time. The person told us, "They have to get the tablets out for me as I can't do it." Another person told us, "Weekends are the worst. They [care workers] are meant to come at 7 a.m. Sometimes it is about 10:30am. This means I have to stay in bed and don't get my tablets on time. I dread weekends coming."

Records showed staff had completed medicines training but had not had their competency to administer medicines checked in line with the provider's medicines policy. One staff member told us this training had been part of their induction and included learning how to complete medicine records. They added, "We should be checked by a senior but that hasn't happened for ages." Another staff member said, "There have been no checks since the old manager left and some of the new staff are not signed off (as competent to administer medicines) but there are still doing medication." Monitoring staff's practice is important in ensuring staff continue to have the knowledge and skills needed to continue to administered people's medicines safely. We asked to see the records of medicines competency checks. The provider told us they thought this had been completed, but was unable to provide us with evidence of this.

One relative told us a person's medicines had been recorded as given, but had not been. They said, "They [care staff] sign the MAR (Medicines Administration Record) to say they have given the inhaler when they have not, or they don't sign the MAR at all. They are just rushing so much."

Our discussions with staff informed us some people did not have MARs in their homes to enable staff to record and evidence the medicines administered. To ensure records were maintained, staff had improvised. For example, one member of staff had written on the back page of the previous month's MAR. Another had hand written onto the MAR, the medicines a person received. The information they used was from the person's medicine boxes, and not the person's most recent prescription. This meant there was a risk that they could administer wrong doses of medicines. We showed this to the nominated individual who acknowledged medicine recording was, "A shambles."

We reviewed the medicine administration records (MAR) for seven people. We found records had unexplained gaps which meant we could not be assured people had received their medicines as prescribed. For example, one person had been prescribed medicine to supplement calcium in the diet. However, there

was no information to show the person had been supported to take their medicine on four occasions during one month. Another record dated June 2017 showed staff had not recorded if the person had received their medicines on 14 separate occasions. This meant we could not be sure people were receiving their medicines as prescribed.

During our visit we were informed another person had not received their prescribed medicine during a care call the evening before. The co-ordinator confirmed this. However, when we asked what action had been taken we found the provider's medicines procedure had not been followed. This was because medical advice had not been sought. The co-ordinator told us they were not familiar with the provider's medicine procedure because they had only been in post two weeks and had not had time to read policies and procedures. We discussed this with the nominated individual who said, "[Co-ordinator] has been thrown in at the deep end. It has been very difficult." They told us they would address this.

Systems to check safe administration of medicines were not being used. Most MAR sheets had not been returned to the office for auditing since May 2017. This meant the provider could not be assured people were given their medicines safely and as prescribed.

Where we found a MAR dated March 2017 had been audited in September 2017. The audit identified there were 'missing signatures', but did not detail how many were missing and on what dates, so the provider could check whether the missing signatures meant the person had not received their medicines.

This was a breach of Regulation 12 (1) (2) (g) HSCA (RA) Regulations 2014 Safe Care and treatment.

People we spoke with told us they felt safe with their regular care workers, and relatives agreed.

The provider understood the importance of assessing people's risks related to their heath and well-being, and had a system of risk assessments in place.

Risk assessments however, did not always give staff all the information they needed to keep people safe, and often differed from information contained in people's full care plan. For example, one person had been assessed as being at risk because of poor mobility. Their care plan recorded the person should be supported by two care staff. This information was not included in the person's risk assessment. The risk assessment stated the person was 'non weight bearing', and had a 'ceiling hoist' in place, but there was no information on what the risks were, and a section entitled 'comments and action to be taken' had been left blank. We were concerned staff who were not familiar with people, would only read the risk assessment, and would not have all the information they needed to keep people safe.

Records showed staff were recruited safely. For example, prior to staff working at the service, the provider checked their character by contacting their previous employers to obtain references, and the Disclosure and Barring Service (DBS). The DBS is a national agency that keeps records of criminal convictions. This was to minimise the risks of recruiting staff who were not of suitable character to support people in their own homes. Staff confirmed they were not able to start working for the provider until the required checks had been received.

Staff received training in safeguarding and were confident about their role in keeping people safe from avoidable harm. Staff knew what to do if they thought someone was at risk of abuse. However, staff were not confident the management team would take appropriate action if they did report any concerns. One staff member told us they had informed the deputy manager of their concerns about a person's mental health and how this may affect the person's safety. They added, "I have sat at home worrying. I don't know if

anything has been done." Records confirmed the concern had been recorded but there was limited detail about the actions taken or agreed. This meant we could not be assured the person was safe. We discussed this with the regional manager and asked them to take immediate action. Before the end of our inspection visit, the regional manager confirmed action had been taken to ensure care staff were aware of the situation and knew how and when to alert others to ensure the person was safe.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we rated 'effective' as 'good'. At this inspection we found improvements were required.

People and relatives told us their regular care staff were well trained and knew how best to meet people's needs. One person explained, "The care staff are good at their job. I cannot fault them. It is more the organisation and management of it." Another person told us, "Of course [care workers are well trained], they know what they are doing."

Experienced staff told us they had an induction when they first started working at the service. This included being assessed for the Care Certificate, and working alongside more experienced members of staff before attending to people on their own. The Care Certificate assesses staff against a specific set of standards. Staff have to demonstrate they have the skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support. One recently recruited staff member told us they had not received an effective induction. They said, "I don't know about my induction yet. Hopefully thing will be sorted." They added, "I haven't been shown the policies or procedures it's been very busy. No one has told me anything. I think I will need to read them in my own time."

We reviewed the training records of two care staff members who started working for the provider in May 2017. There was no evidence shadowing (working alongside experienced staff), assessment or competency checks had been completed to ensure they had met the expectations set out in the Care Certificate. We raised this with a recruitment manager, who told us they were sure this would have been done, and that they would send us evidence of completion after our inspection visit. We did not receive this.

Experienced staff told us the provider had not observed or checked their practice since the previous manager left the service in May 2017. We raised this with the provider's management team, who told us they thought these checks had been taking place. Following our inspection visit, we saw some evidence that a small number of people had been contacted in early September 2017 to ask them if they were satisfied with their care workers. The provider explained the lack of senior staff after the previous manager and care co-ordinator left the service, had 'probably' made it difficult to maintain these checks.

Staff spoke positively about the training they had previously received. One staff member commented, "My training is up to date but I don't think any is planned. We used to know in advance." Another staff member said, "The training I had was good." The provider kept a record of training staff had undertaken. This showed the majority of training was up to date for the majority of staff.

Staff told us they had not had the opportunity to meet individually with senior staff since the previous manager left. One staff member commented, "I have not had a spot check since before [previous manager] left. I have had no supervision meetings or anything. We raised this with the nominated individual, who acknowledged this and again told us this would be rectified when a senior team was fully recruited. We were concerned the lack of supervisions and spot checks meant the provider could not assure themselves staff were working in line with the provider's expectations.

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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

People told us staff asked for their consent before supporting them, and ensured they were happy with how care was provided. One person said, "Yes, they always ask me what I want. They've got good manners." Staff understood the importance of seeking consent from people. One staff member told us, "I always ask clients what they would like me to do when I start the call."

Staff we spoke with had limited knowledge and understanding of the MCA. However, they understood the need to seek consent and to support people according to their choices and preferences. Whilst staff said they had not heard of the MCA, they understood the need to support people to make their own decisions, and the need to raise concerns about whether or not people had capacity to make their own decisions. They understood they could not force someone to do something against their will.

People's care records included some information on what decisions they could make for themselves, and those where they needed some support.

Most people we spoke with told us they managed their own health and did not need staff to help them access medical professionals. Care records showed some evidence of staff alerting medical professionals when this was required.

Requires Improvement

Is the service caring?

Our findings

At our last inspection we rated 'caring' as 'good'. At this inspection we found improvements were required.

People and relatives spoke warmly about care staff they knew well and who were familiar with them. However, they did not speak positively about care staff they did not know well.
One relative commented, "Some staff are absolutely excellent. But, some are telling me to buy dry shampoo as they don't have time to wash [name's] hair. Half the time they don't even have time to make [name] a cup of tea or a sandwich."

Talking about their regular care worker, another person commented, "They will do anything for you. It doesn't matter what you ask them, they will do it." Another person said, "The carers are brilliant. They do a good job." A third person told us, "She [care staff] is brilliant, more like a friend."

People and relatives told us they did not feel the provider was caring, and that the service they received since May 2017 had deteriorated so their care was inconsistent and often rushed. They told us they felt senior staff did not care about what was happening. Comments included, "I phone the office and no-one answers, they don't phone to tell you your call is not happening. There is no communication.", "I could phone the office before, but now they don't want to know.", and, "When no-one came recently I phoned the office, who told me they had no-one to come to me. I said I would get my children to help me, and they just said, 'okay, can we cancel you then?'" People and relatives also told us office staff had sometimes been 'rude' and 'dismissive.' People and relatives told us this had a detrimental impact on their well-being. One relative commented, "It has all made me really ill. I have no faith in the office whatsoever."

People told us the service provided since May 2017 did not always reflect the choices they had made about their care and support. For example, one person said, "They came out this morning with a male care worker as well as a female. I never agreed to that, I don't need two carers and I would not want a male carer so I just sent them away."

Staff told us they were committed to providing a caring service which respected people's choices, but told us that, since May 2017, they felt the way there were expected to work meant this was not always possible. They also felt the provider did not always care about staff. One staff member explained, "I have been in situations where I have had 17.5 hours of calls to do and only nine hours to do them. I have been asked to 'short call', meaning I am asked to do what is needed quickly and then leave."

People told us care workers respected their privacy and dignity. One person told us, "I have no qualms, she [care worker] respects my privacy. We've got to know each other and we have a laugh."

People's care records reminded staff they must respect the fact that they were going into people's own homes. For example, staff were reminded to knock and introduce themselves on arrival. Records showed this was one of a number of key questions people were asked by the service when it sought feedback about how satisfied people were with the care and support they were provided. However, the provider had not

routinely sought feedback from people since May 2017.

Staff understood the importance of maintaining people's privacy when personal care was provided. One staff member told us, "We make sure clients are covered with a towel." Another staff member said, "We close the curtains and doors."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we rated 'responsive' as 'good'. At this inspection we found improvements were required.

Relatives told us people were not receiving care from people they knew. One relative told us, "We have had several carers who have never been before. This makes my husband very upset and anxious. Some of the carers have said they are leaving. Everything has gone to pot. It is as if the office don't care." One relative explained, "We get different carers every time so [name] has to explain every time what needs doing.

People told us they did not receive satisfactory responses when they complained. One person commented, "I've made many complaints but you may as well talk to yourself. All they say is they are trying to get it right." Another person said, "I have complained but they just say, 'okay then.'" A relative said, "I sent a letter of complaint to the manager two weeks ago. I have had no response, no contact at all from the office about it."

The provider did not always record or respond to complaints according to its policy and procedure. One relative explained they had made a complaint in August 2017 regarding missed and late care calls. When we reviewed the provider's complaint records, we found this complaint had not been recorded.

We looked at the service's complaint record which showed two complaints had been recorded during 2017. This was not consistent with what some people and relatives had told us about their experience of using the service. When we asked to see records of more recent complaints we were told they were not available at the time of our inspection visit. The nominated individual said, "The manager has put them somewhere but I'm not sure where." This meant we could not be assured complaints were being managed in line with the provider's procedure. The regional manager told us, "The plan is once there is an electronic complaints system in place, we will be able to access them at any office. The plan is in the pipeline somewhere."

This was a breach of Regulation 16 (1)(2) (a)(b)(c) HSCA (RA) Regulations 2014. Receiving and Acting on Complaints.

The provider kept a record of compliments received about the service. One was from a relative thanking the service for the care and support provided to their relative.

Some care plans contained detailed and clear information for staff to follow. For example, two people's care plans contained guidance for staff on how to support them with medical equipment. The information was clear, and included details of who they should contact if they had any concerns about the equipment. However, care plans had not always been updated to reflect people's needs. Whilst staff who were familiar with individuals knew how they wanted their support to be provided, other staff who had to cover calls to people they did not normally support, did not have the information they needed.

Staff told us they always read care plans to enable them to understand people's care and support needs and how they wanted this to be provided. However, staff told us care plans were not up to date which

caused them concern because they were visiting people they were not familiar with. For example, one staff member told us on arrival at a care call she explained to the person she had come to assist them to empty their catheter. The person informed the staff member they no longer had a catheter. The person's care plan had not been updated. Staff told us if they were informed of any changes by people or family members they left each other 'notes' in the hope that the staff member following them would read it.

Staff told us they were not able to share changes in people's needs with the office because there was 'no one in the office'. One staff member told us one person had been prescribed a nutrient drink because they were not eating. They said they had added a note in the folder so other staff were informed but the care plan had not been updated. They added, "Normally the care plan would be reviewed by the senior and updated but we haven't got any. So you have to hope staff read the note you leave." We were informed by another staff member that a person now needed to be cared for in bed due to deterioration in their health. They explained all regular staff were aware of this. However, when we reviewed the person's care plan, it recorded, "I would like to be left in my armchair."

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we rated 'well led' as 'good'. At this inspection we found improvements were required.

The previous registered manager left in May 2017. Since that time, the provider had recruited a new manager and a care co-ordinator, who were supported by a regional manager. The nominated individual told us they still needed to recruit senior carers, and that this recruitment was underway.

When we last inspected the service in April 2016, 93 people were supported by the provider. This had risen to 187, after new contracts were taken on by the provider, and staff had been transferred over from other providers from April 2017 onwards. In August 2017, Universal Care Services had become part of a bigger company, Clece Care Services, though it continued to operate as Universal.

People and relatives told us the service had deteriorated significantly over the past four months. One person said, "It used to be absolutely brilliant when [previous manager] was there, but since they left, the service has gone to pot." Another person explained, "The care workers are good, really nice, the management is not very good." A relative commented, "There were hiccups before all the changes, but it has got worse. It was pretty good before."

Staff agreed the service had deteriorated, comments included, "If you had asked me four months ago I would have said yes [it is a good place to work]. Now it's an absolute no. The only reason we are here is because of our clients. We worry about them.", "I love my job. I love being with the clients and meeting people. But at the moment it's all gone downhill." Another said, "No, it's not a good place to work at the moment. But I have a duty and responsibility to my clients so I have to carry on.", and, "From the last inspection to this one, things have changed to diabolical."

People and relatives told us they did not feel the service was well managed, and were unhappy with the responses they received from senior office based staff. One person told us, "I don't see anyone from Universal now. Just the care worker." A relative commented, "Some of the office staff have a terrible attitude when you ring. My relative is sitting there in a wet incontinence pad and they [office staff] say I have an attitude." Another relative explained, "We ring the office but they never know where the carers are or when they would be with us. They did not even seem to want to find out." They added, "It has been worse since all the office staff left. I could phone the office before but now they don't want to know."

Staff told us the support they received from the manager was either not available or not effective. Comments included, "No one wants to take responsibility for what is going on.", "New manager is not approachable. Probably, because we never see them. They are always out doing calls.", "Before the registered manager left there were no missed calls and there was always someone to speak to in the office and to get advice from. I felt supported then.", and, "I asked for the contact number for [company ownership] because I wanted to raise my concerns but no one would give it to me."

Staff told us they did not feel supported by senior, office based staff. Comments made included, "There is

no–one to talk to because the manager is always out.", "It frustrates me. When a problem occurs I don't know where to go." And, "Often there is no –one in the office. The phone just rings so it's difficult to know what to do." "[Admin worker] has been very supportive but they have to do things the manager should be doing." Staff also told us the support provided out of hours was not effective. One staff member commented, "[Out of hour's manager] can be very rude. They are rude to staff and clients." Clients have told us they tried the out of hours and no one answers." We asked to see records of the 'out of hours' calls. The nominated individual was not able to locate any records since 15 August 2017. It was not possible to be sure information from out of hours was shared with the management team.

Staff told us they had not had the opportunity to attend a staff meeting since before the previous registered manager left the service. They told us this added to them feeling unsupported and that communication with the management team was poor. Records showed the last staff meeting took place in November 2016, and staff told us they were not aware any staff meetings had been planned.

The provider had not checked or audited the quality of the service since the previous registered manager left in May 2017. For example, most care plans we looked at had not been reviewed since May 2017. The provider's policy stated care plans should be reviewed quarterly, or more often if changes to 'needs and preferences occur.' The provider acknowledged this had not been happening in line with their policy, and told us they hoped this would be rectified with the recruitment of more senior staff. When we raised our concerns about the lack of auditing of MARs with the nominated individual, they told us they thought MAR sheets had been returned [to the office], but there were currently no senior staff available to check them, as they had been out covering care calls. They acknowledged this meant they were not assured of safe medicines administration, and told us this would be rectified through the recruitment of senior staff.

The lack of effective quality monitoring, meant the provider did not have up to date information on the difficulties the service was experiencing. However, the nominated individual told us they knew the service provided had not been good enough. They said, "We know there are some issues and concerns. We are doing our best to sort them out. It's been a difficult period. We have tried hard to support everyone. We know there is lots to do. We know where we have gone wrong. The deputy is returning form leave and we need to recruit four seniors. Without a strong management team we are struggling." The regional manager added, "We are not happy or confident with the current situation. A catalogue of issues has impacted and brought us to the current situation."

The provider explained the current difficulties with scheduling and provision of consistent, reliable support for people, were the result of having brought over staff from other providers. They explained they then had to honour pre-booked leave which had caused them significant difficulties over the summer period. They also told us when the previous management team left the service, all call schedules had been lost from the system, and they had been trying since to establish when calls needed to happen.

The provider acknowledged plans had not been in place to manage the above difficulties before they occurred, or subsequently. For example, we reviewed the business continuity plan. This was last updated in January 2016, and was due for review in January 2017. This had not taken place. We asked the provider if they had a contingency plan in place to reduce the risks associated with loss of data, given the difficulties this had caused them over the three months prior to our inspection visit. We were told there 'should' be one, but this was not available for us to review. The nominated individual acknowledged people would be at risk if further data was lost, and assured us they would develop plans to 'back up' data to reduce the risk.

This was a breach of Regulation 17(1)(2) (a)(b)(c)(e) HSCA (RA) Regulations 2014. Good governance.

During our introductory discussions with the provider, we were told that action plans were in operation to improve the service, given the concerns people, relatives and staff had expressed since the previous registered manager left. However, these were not available for us to review.

There was evidence that some people had been contacted in early September 2017, by the provider to ask whether or not they were happy with the care staff who supported them, and with the service provided. However, we did not see any analysis of the results of these calls, and there was no action plan available for us to review to assure us the provider was taking steps to improve the service as a result. The provider told us they had written to everyone who used their service to explain and apologise for the difficulties they had experienced. We saw evidence in people's care records that this letter had been sent out to people.

Following our inspection visit, the provider sent us an action plan detailing how they planned to resolve the issues we had uncovered during our inspection visit. We discussed this with the clinical lead for Clece Care Services, who explained they were now taking responsibility for overseeing improvement. They explained they would ensure whatever was needed to improve the service for people would be provided. They had a clear understanding of the areas for improvement, and assured us the action plan would be put into practice. They agreed not to take eon any new care packages until the service had made sustained improvements, and also to send us monthly updates on their action plan.

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 Medicines were not always administered safely and as prescribed. Systems designed to ensure safe and appropriate administration of medicines were not used.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had not always recorded or acted on complaints received about the service.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not planned appropriately to ensure an expansion of the service could be safely managed. Systems designed to check on and improve the quality of the service were not used. People, relatives and staff did not feel well supported by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were enough skilled and appropriately trained staff available to meet people's needs safely. The provider had not ensured staff were

properly deployed in order to meet people's needs safely.