Universal Care Agency Ltd

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Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Universal Care Agency is a provider of community home care services providing personal care to seven people aged 65 and over at the time of the inspection. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
The provider had not taken appropriate steps to improve the service and to ensure people received safer care. An action plan was in place to address the warning notice served by CQC at our previous inspection. However, none of the requirements of the warning notice had been met.

Risk assessments and care plans did not always provide guidance to staff about how to support people effectively. Care plans and risk assessments did not always contain enough detail about people's specific medical conditions.

'As required' medicine records were not always in place. Where they were in place, they did not include enough detail to guide staff as to their appropriate use.

Quality assurance systems had not been effective in identifying the concerns we found at this inspection or fully addressed concerns from our last inspection.

This was a targeted inspection that considered medicines management, safe care and treatment and governance. Based on our inspection of these areas we were not assured the provider was meeting the Regulations.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 13 August 2021) and there were two breaches of regulations. 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.

Why we inspected
We undertook this targeted inspection to check whether the Warning Notice we previously served in relation to Regulation 12 and Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. The overall rating for the service has not changed following this targeted inspection and remains Requires Improvement.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

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

We have identified breaches in relation to medicines management, risk management and good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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? Inspected but not rated.	**Inspected but not rated**
Is the service well-led? Inspected but not rated	**Inspected but not rated**

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Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check whether the provider had met the requirements of the Warning Notice in relation to Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspection team
The inspection team consisted of one inspector.

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 four days' 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 14 September 2021 and ended on 23 September 2021. We visited the office location on 14 September 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection-
We spoke with one person who used the service and three relatives about their experience of the care provided. We spoke with three members of staff including the nominated individual who was also the registered manager and two care workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included six people's care records and medication records. 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.

Inspected but not rated

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question, we had specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served. We will assess all of the key question at the next comprehensive inspection of the service.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to assess the risks to the health and safety of services users and do all that is reasonably practicable to mitigate any such risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection enough improvement had not been made and the provider remained in breach of this regulation.

● At the last inspection we found where risks had been identified, there was not always guidance to identify actions staff should take in the event of the risk occurring. For example, a person was at risk of blood clots with prolonged immobility and the risk assessment was completed however, it did not identify what the signs of a blood clot were or what to do if a blood clot was suspected. At this inspection we found the same concern. The care plan and risk assessment had not been updated to include this information. This meant the person remained at risk if the staff did not know the procedure to follow.
● At the last inspection we found, one person's care pan stated, "handling equipment." However, there was no detail about what the handling equipment was or how to use it. The same person had a catheter but there was no care plan or risk assessment to guide staff how to use it. At this inspection the care plan had been updated to read, "Manual handling equipment," however, the concerns we had remained the same. The care plan had been added to, to inform staff to change the catheter bag at specified intervals however, the care plan did not include detail on how to do this. We asked two staff members how they changed a catheter bag. They were able to describe the process in good detail. This meant new or unfamiliar staff may not know how to manage this person's catheter safely or how to spot any catheter related concerns.
● Care plans continued to fail to contain enough information about people's specific medical conditions. For example, one person's care plan identified they had chronic kidney disease stage three, however, there was no information about this condition or signs to look out for if the person's health deteriorated. We spoke with two staff who told us they monitored his urine for any changes but did not mention any other signs to look out for with this condition, for example, tiredness, swollen ankles, hands or feet, shortness of breath and feeling sick. There was no guidance to staff on what action to take should these symptoms occur. This meant the person was at risk of not receiving the correct medical interventions because the staff did not know how to identify when they needed support.
● One person's care plan said they had a specific medical syndrome. There was no other information relating to this condition. We asked two staff members what the condition was and how it affected the person, they told us, "I am sorry, I don't know," and, "Never heard of it." This meant that staff did not have

the information required to support and understand this person's condition. This syndrome causes a person whose vision has started to deteriorate to see things that aren't real (hallucinations).

● One person's care plan stated they were on a, 'normal diabetic diet.' The care plan had T2DM listed under their conditions. We asked two staff members what T2DM stands for, both staff members did not know what it meant. T2DM is a medical abbreviation for type 2 diabetes. We asked both staff members, "Who has diabetes?" One staff member told us, "[person's name] is an insulin dependent diabetic, [person] does it themselves." The other staff member told us, "No-one that I know of." This meant some staff were not aware of the person's condition and had no guidance how to support this person with signs to look out for should they deteriorate. This put the person at risk of harm.

The provider failed to assess the risks to the health and safety of services users and do all that is reasonably practicable to mitigate any such risks. This placed people at risk of harm. This was a repeat breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● One care plan we identified as not containing enough information at the last inspection had been updated to include details of the person's medical conditions.
● One person we spoke with told us, "I haven't seen a care plan or a risk assessment. I haven't seen any I guess that [registered manager] does have that. The service is first class, carers turn up on time, they ensure flat tidy and clean and make beds.

Using medicines safely
At our last inspection we found the provider had failed to ensure the proper and safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection enough improvement had not been made and the provider remained in breach of this regulation.

● At the last inspection there were no 'as required' medication protocols in place. At his inspection there were two as required protocols in place however, these did not include the information required to guide staff as to their correct use. For example, one person had an 'as required' medicines protocol in place for Cosmocol. Cosmocol is a laxative used to treat constipation. The 'as required' medicine protocol guided staff to administer three different amounts, it read, "The recommended dose is 16 sachets daily, all of which should be consumed within 6 hours," "Take the contents of 1 sachet as directed," and "The recommended dose for constipation is one sachet taken one to three times daily." It was not clear what the prescribed dose was, or when it should be administered. We reviewed the medication administration record for Cosmocol, it had not been administered more than three times in any one day. This meant the person was at risk of receiving too much or not enough medicine to support them with their condition and they may be at risk of harm if they were being supported by new or unfamiliar staff however, we did not find any evidence that this person had been harmed.
● The 'as required' medicines protocol stated, "This course of treatment should not normally last longer than two weeks." However, there was no guidance when staff should seek medical advice. Staff we spoke to told us conflicting information about when they would administer Cosmocol and one staff member could not tell us how long they would administer it for. We spoke to the registered manager about this who told us they would investigate it and ensure the 'as required' medicines protocol was updated.
● The same person's care plan stated they were prescribed 'Codydramol for pain relief as required four hours apart.' There was no information to state what the maximum dose should be, how the person identifies as being in pain or how long this medicine should be administered prior to seeking medical advice. There were no records relating to this medicine on the MAR chart or the 'as required' medicines

chart.

● The registered manager told us only one person had support with their medicines however, care plans and risk assessments told us staff apply prescribed creams to people, for example, Ibuprofen gel, Zerobase and Dermol as well as prompting people to take their medicines. One person's care plan stated, '[Person] manages own medication but may unintentionally forget.' The next paragraph stated for lunch time and teatime, 'prepare food, fluids and any medication requirements.' The evening description stated, 'Remind [person] to take their Iron tablets.' The nominated individual told us there were no MAR charts, PRN records, body maps or cream charts for any of these people however, a relative told us, "Staff administer creams we show them what creams they are prescribed by the doctor and they fill in a chart. They do it properly." We spoke to the registered manager about this who told us there were "no 'as required' records for this person, currently using over the over the counter freeze gel." There were no homely remedy records for this person.
● At the last inspection staff had not had their competency to administer medicines assessed. At this inspection staff had still not had their competency to administer medicines assessed. We spoke to the registered manager about this who told us they had attended training to assess staff competency however, had difficulty passing the test. Following the inspection, the registered manager sent us a certificate to show they were now able to assess competency however, at the time of writing this report staff had not had their competency to administer medicines assessed. There was a risk staff who had not been competency checked may not be competent to administer medicines.
● There was a MAR chart in place for one person which identified the name, route and dose of the medication. Instructions were also recorded on the MAR however; where a medication had been reduced by a medical professional this had not been identified on the MAR chart. This meant there was a risk of harm to this person due to potential overdose if new or unfamiliar staff were supporting them. We have raised a safeguarding referral about this.

The failure to ensure the proper and safe management of medicines was a repeat breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager showed us a blank 'as required' medication protocol template that they had developed however, this was not yet being used.

Inspected but not rated

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 Requires Improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question, we have specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served. We will assess all of the key question at the next comprehensive inspection of the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At our last inspection the provider had failed to assess, monitor and improve the quality and safety of the service provided in the carrying on of the regulated activity and the failed to maintain accurate records in respect of each person. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection enough improvement had not been made and the provider remained in breach of this regulation.

● Effective systems had not been established to assess, monitor and improve the quality and services provided to service users and accurate and contemporaneous records
● The provider had put some systems in place to monitor and assess the quality of the service and to drive improvements for example they had developed an action plan following our last inspection, however; quality assurance audits were not in place for example, to check the quality and accuracy of care plans, risk assessments and medicines records. Where the provider told us, they had completed an audit but not documented it, they had not identified the areas of concern we found during the inspection. This included risk management, medicines management and maintaining accurate records. We have reported on this in more detail in the Safe domain of this report.
● People were at risk of not receiving their medicines safely because the registered manager had failed to ensure that medicines audits took place. We spoke to the registered manager about this who told us, "I have done medication checks, I just haven't documented them." Any checks that had been undertaken had failed to identify the concerns we found during this inspection.
● Systems were not in place to ensure staff competence was checked to administer medicines. There were no records available to demonstrate staff had undergone competency checks. ● Quality assurance audits of care plans and risk assessments were not taking place. Records did not always reflect how the service was meeting people's specific health conditions and managing the risks that this might present with. We have reported more about this in the Safe domain of this report.

The failure to assess, monitor and improve the quality and safety of the service provided in the carrying on of

the regulated activity and the failure to maintain accurate records in respect of each person was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activity) Regulations 2014.

● Two of the relatives we spoke with were very positive about the registered manager, their comments included, "He is very helpful," and, "I am very impressed actually, the honesty and the intelligence of the registered manager and the honesty, intelligence and integrity of carers sent round provides care of a very high quality." A third relative did not have confidence in the registered manager however told us, "The girls [care staff] run it, they work beautifully."
● One relative told us, "[Person] used to have pressure sores, they are cleared up now, they do a fantastic job."

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess the risks to the health and safety of services users and do all that is reasonably practicable to mitigate any such risks. This placed people at risk of harm. This was a repeat breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The failure to ensure the proper and safe management of medicines was a repeat breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We propose to impose conditions on the provider

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The failure to assess, monitor and improve the quality and safety of the service provided in the carrying on of the regulated activity and the failure to maintain accurate records in respect of each person was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activity) Regulations 2014.

The enforcement action we took:

We propose to impose conditions on the provider