Universal Care Services (UK) Limited

Universal Care Services Corby

Inspection report

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05 July 2019

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Universal Care Services Corby is a domiciliary care service providing personal care to 118 younger adults and older people with dementia, physical disabilities and mental health needs.

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
People did not always receive care at the time they needed it and had experienced missed calls. They did not always feel safe as at times staff they did not know would attend to provide care. People told us staff did not always show their identification. People did not feel confident in the service's ability to manage their rota effectively.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. Staff respected people's preferences and wishes regarding their care delivery However, the policies and systems in the service did not support this practice. Mental capacity assessments and best interest decisions had not been undertaken for people that lacked capacity to make specific decisions about their care and treatment.

Quality assurance systems and surveys had identified areas for improvement. The service had an action plan in place to address concerns such as late visits and dissatisfaction with complaints management. Implementation was in the early stages at the time of inspection and needed to be further developed and embedded in practice to improve people's care experience. The registered manager was aware of their legal requirements. Whilst statutory notifications had been submitted to CQC, these were not completed in a timely manner.

People were supported by staff that had been safely recruited. Staff had a good knowledge of risks associated with providing people's care, including infection control. Staff had received adequate training to meet people's individual care needs, their competency was assessed before they gave people their medicines. Staff knew how to identify, and report abuse to keep people safe. Accidents and incidents were reported and reviewed. Measures were put in place to reduce risks to people.

People told us regular staff were kind, caring and compassionate. They took the time to find out people's hobbies and interests. Staff enjoyed their work and treated people as if they were a family member. People's diversity was respected and embraced. Staff were respectful and open to people of all faiths and beliefs, and people's privacy and dignity was respected. People's care plans were being developed to include more information about what was important to them to assist staff to provide more personalised care.

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

Rating at last inspection
This service was registered with us on 04 July 2018 and this is the first inspection.

Why we inspected
This was a planned inspection.

Enforcement
We have identified breaches in relation to Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Universal Care Services Corby

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.

Inspection team
The inspection was carried out by one inspector, two assistant inspectors and two Experts 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 04 July 2019 and ended on 05 July 2019. We visited the office location on 04 July 2019 and spoke with staff. We spoke with people, their relatives and additional staff on 05 July 2019 by telephone.

What we did before the inspection

We reviewed information we had received about the service. We sought feedback from the local authority, professionals who work with the service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. 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 16 people who used the service and four relatives about their experience of the care provided. We spoke with nine members of staff including the registered manager, compliance manager, supervisor and care staff.

We reviewed a range of records. This included 12 people's care records and medication records. We looked at four 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 audits of call times and requested copies of policies.

Requires Improvement

Is the service safe?

Our findings

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

This is the first time we have inspected the service and we have rated this key question Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

● People told us, and records showed, they often received their care later than planned. People said, "They [office] are always very quick to tell me why the carer hasn't got there, but some days it can take up to two hours to get me somebody else, by which time I've gone past needing them [staff];" "Only last week I missed a hospital appointment because the early carer didn't appear." and "They [staff] were over one hour late coming today...they never called to say [they were]held up." A relative told us, "I am frustrated with the people that set the rotas up. The times are all over the place and [name] needs [medicine] on time."

● The provider had identified through surveys and audits an issue with late calls and were acting to reduce these. However, we found this had not been effective as people were still experiencing late calls.

● Some people had experienced missed calls. One person told us, "I have had missed calls and had to phone them [service] to get someone to come." Another person had not received a visit due to an error with the electronic rota management system. This meant they had missed their medicines.

● People were not always supported by staff they knew, this made people feel unsafe. People said, "There are still some days when the front door will open and the carer who comes in, is one that I've never met before"; "I get different ones [staff] all the time" and "I do still see carers who I've never met before, particularly on weekends." A staff member told us, "There are not enough staff available at weekends…just lately we have been shorter staffed, weekends are bad." Rota's showed people were not always supported by consistent care staff.

● Staff told us travel time between local calls was enough. However, travel time was not always enough in particular geographical areas due to the distance between calls. This meant staff needed to leave some visits early or arrive late to the following visit.

Staff were not effectively deployed to ensure people's care was delivered at the time they needed. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection the provider told us they would introduce additional measures to improve call times and would undertake a survey to determine how people would like to be informed of which staff were due to attend their visit.

● Staff told us they did not start work with Universal Care Services until safe recruitment checks had been undertaken. This was to ensure staff were suitable to work with vulnerable people. One staff member told us, "Once my DBS (Disclosure and Barring Service check) came through, I started shadow shifts and work."

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe receiving care from their regular carers. One person told us, "They [staff] support me to get dressed and have a shower and I could not do it safely without having them here helping me." Another person told us, "I feel quite safe with them [staff]." People that did not receive consistent care told us they did not always feel safe. One person told us, "New [staff] have turned up and knocked me over saying they didn't know I had a [sensory impairment]"

● People told us staff did not always wear uniform or ID badges. One person told us, "They [staff] need reminding that they should be showing me their identity badge, because although they are in the uniform, it's only the identity badge that actually shows me that they are who they say they are." Another person told us, "Today was the first day they [staff] turned up in uniform with an identity badge on."

● Staff were trained in safeguarding procedures and knew the potential signs to look for that could indicate abuse. Staff told us they would immediately report any safeguarding concerns and were confident they would be acted on by the registered manager to keep people safe. They also understood how to raise any safeguarding concerns with external agencies.

Assessing risk, safety monitoring and management

● Risk assessments for falls, skin damage, eating and drinking enough and specific health needs were reviewed at regular intervals to ensure they were reflective of people's needs. A comprehensive fire risk assessment had been completed for a person that smoked. This included detailed instructions for staff to follow to reduce the fire risk, such as soaking and washing clothing inside out to thoroughly remove traces of flammable creams.

● Staff told us they had received training to use equipment in people's homes. One staff member told us, "We check the date on the [lifting equipment] make sure it has been inspected before we use it."

Using medicines safely

● People told us staff always made sure they received their prescribed medicines. One person told us, "[Staff] do prompt me and they make sure that I've had my tablets every morning." Staff had received training to administer medicines and their competency had been assessed. Clear instructions were available for staff to help them identify when people needed to be given 'as required' medicines.

● Medicines Administration Records (MAR) were electronic and were audited weekly. The provider had identified issues with the recording of medicines on the electronic MAR. They had introduced a 'back up' paper document in people's home to ensure medicines administration was recorded consistently and that staff could identify when medicines were administered.

Preventing and controlling infection

● Staff had access to personal protective equipment (PPE) such as gloves and aprons and had a good knowledge of infection control procedures. They had received infection control training.

Learning lessons when things go wrong

● Staff knew how to report accidents and incidents. These were reviewed by the management team to identify themes, trends, learning and actions required to reduce risk to people. For example, the service had identified one person had increased falls when staff were not present. They made a referral to the falls team to determine what additional measures could be put in place to reduce the risk of falls for this person.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first time we have inspected the service and we have rated this key question Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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. Where people may need to be deprived of their liberty in order to receive care and treatment in their own homes, the DoLS cannot be used. Instead, an application can be made to the Court of Protection who can authorise deprivations of liberty

We checked whether the service was working within the principles of the MCA.

- Mental capacity assessments and best interest decisions had not been undertaken for people lacking capacity to make certain decisions. The registered manager was unable to identify during our inspection how many people did not have capacity to consent to their care and treatment. This meant people's preferences for care and treatment had not been considered and there was a risk care would not be delivered in their best interests.
- Some people's plan of support and records of consent were signed on their behalf by relatives. There was no evidence that the service had been provided with proof there was a legal authority to do this, for example through a Lasting Power of Attorney. A lasting power of attorney is a legally appointed person that can make decisions on a person's behalf when they are unable to make decisions as they lack capacity. Where Lasting Power of Attorneys had been appointed the service had not assessed people's capacity to make specific decisions about the planning of their own care.

The service was not compliant with the requirement of the MCA to assess whether a person has capacity to agree to care and treatment and consider what is in a person's best interests. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection the provider told us mental capacity assessments and best interest decisions would be undertaken and they would seek confirmation of lasting powers of attorney for health and welfare.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's physical, social and wellbeing needs were assessed before receiving care from Universal Care Services Corby. This assessment informed the development of people's care plans.

Staff support: induction, training, skills and experience

● People received care and support from competent and skilled staff. An induction process was in place for new staff, including a 4-day induction programme, shadowing more experienced members of staff for two days and a competency assessment. Staff undertook the Care Certificate, a set of standards nationally recognised in the care sector that staff are expected to follow. The provider told us they planned for staff to undertake dementia and end of life training to further enhance their knowledge and understanding of people's needs.

● Staff told us they felt supported by the management team and could approach them at any time should they need support. People received regular supervisions and annual appraisals to review their development. Spot checks were undertaken to ensure staff met people's needs as planned.

Supporting people to eat and drink enough to maintain a balanced diet

● People's care plans reflected the support they needed to eat and drink enough and people were supported with preparing and eating meals where this was needed. One person told us, "They [staff] always leave me with a small jug of water on my little table and encourage me to drink at least one, if not two hot drinks whilst they're with me." A relative told us, "I get [name's] breakfast, but they [staff] will leave [name] water and an apple for mid-morning. At lunch time they [staff] will grill or fry something or do a microwave meal depending on what [name] asks for."

Supporting people to live healthier lives, access healthcare services and support. Staff working with other agencies to provide consistent, effective, timely care.

● Regular staff knew people well and recognised when people needed healthcare support. The management team co-ordinated appointments with professionals such as the GP and district nurses. Staff updated the management team if there were changes in people's healthcare needs. One staff member told us, "The district nurse and catheter nurse have been recently for a person… I let the office know."

● People were supported to attend healthcare appointments as needed. The registered manager told us, "If an ambulance is called [during visit time], we advise the carer to stay until someone else can get there such as family. If not, we make sure someone waits with the person. We give the ambulance staff our care plan."

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first time we have inspected the service and we have rated this key question Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People did not always feel cared for by the service and told us, "I don't ever get sent a weekly list so I know who's going to be coming and when"; "When I phoned to complain [about a late call], I was simply told that they [service] were short of carers and that this was the earliest I could possibly get somebody to me by. It made me feel as if it was all my fault. It wasn't very pleasant" and "My timings just get changed around by the office at their convenience and definitely not mine."
- People and regular staff had developed caring relationships together and enjoyed each other's company. One person told us, "All the carers are very nice, caring and considerate with me." Another person told us, "My regular carers really are like family members now. They know all about me and what I like and dislike. I've been able to get to know them over the months they have been coming to me. Nothing is too much trouble, whether that's helping me to organise my washing or making sure that the shopping list has everything on it that I need."
- Staff we spoke with were kind and compassionate and enjoyed supporting people. One staff member told us, "They [people] are like friends, I look forward to seeing them. Another staff member told us, "You've got to give 100% as you are looking after people's lives, I treat people how my family would want to be treated."
- People's cultural and religious needs were detailed in their care plans. A staff member told us, "We drop [name] off at a church meeting so they can have lunch." People's equality and diversity needs were respected.

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was respected. One person's care plan stated, 'I would like to be treated with respect and dignity when being assisted with my personal care on each call'. A person told us, "They [staff] keep me covered when washing me…and they bring me a towel to cover up with." Another person told us, "My regular carers are always very polite and will knock on the door and wait for me to tell them they can come in."
- Staff recognised the importance of confidentiality. Records were stored securely.

Supporting people to express their views and be involved in making decisions about their care

- Staff offered people choices and promoted their independence. One person's care plan instructed staff to, 'Respect [names] decisions and offer [name] choices for what they want to eat and drink.' A staff member said, "We ask people what they want… we always give [people] a choice." One person's aspiration was recorded in their care plan as, 'To get my independence back.' Their care plan identified what the person was able to do themselves such as wash their hands, face and spray deodorant and what they needed

support with to achieve this goal.

● The service had recognised one person needed an advocate. This is someone that can help a person speak up to ensure their voice is heard on issues important to them. The service had referred the person to the appropriate service to ensure advocacy support was provided.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first time we have inspected the service and we have rated this key question Requires Improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

● The service had a policy and procedure in place to manage complaints. Complaints had been addressed but were not always responded to in writing within 28 days as per the services complaints policy. Complaints outcome letters did not provide the complainant with details to refer to the Local Government Ombudsman (LGO) if they were not satisfied with the complaint outcome. The registered manager told us the complaint outcome letter would be amended to include this information and future complaints would be responded to in writing.

● Relatives told us they had made complaints, but these had not always been resolved to their satisfaction. One relative told us, "I have complained about the late calls…They [service] say they are doing their best, but it is still not resolved." Another relative told us, "I have complained when they [staff] have not turned up and they [service] say they will send someone, which they do, but would they if I hadn't phoned?"

End of life care and support

● At the time of the inspection, the service was not providing care to people at the end of their life. The service had not considered people's preferences and choices in relation to end of life care should a sudden death occur. The registered manager told us care plans would be updated to include this information, taking into consideration people's protected characteristics, cultural and spiritual needs. They told us end of life care training would be arranged for staff.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People told us they received personalised care from regular staff that knew their hobbies and interests. One staff member told us, "I like to find out people's personalities and hobbies, it makes the care more human." People told us when their regular staff were not available, staff did not always know their needs or preferences for care delivery. One person told us, "When there are different carers here, I have to go through everything with a fine-tooth comb. It can be dreadfully tiring, particularly if I have a new carer for each of the three visits in a day. I'm exhausted by the time I get to bed."

● Some people's care plans included basic information about their needs, others were very personalised, including information about their likes, dislikes, hobbies, interests and what to do if they were worried or upset. One person's care plan said, 'Smoking and having a cup of tea' helped them if they were upset. Another person's care plan recorded their aspiration as 'To be able to stay at home with my [relative] for as long as I can.' This assisted staff in providing personalised care. The registered manager told us all care plans were being updated to ensure they were consistently person centred.

● Care plans had been reviewed regularly and as people's needs changed. People were involved in their care plan reviews and staff were alerted to changes to care plans via a secure messaging system. Staff told

us care plans contained enough information for them to be able to meet people's needs. One staff member told us, "There is quite a lot of information in the care plan and risk assessment. The office would call and let us know if there have been reviews and needs are different." However, new staff did not always have time to read people's care plans before providing care.

● People's preference for gender specific staff was respected and recorded in their care plan. People told us staff offered them choices, and their decisions were respected.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People's communication needs were detailed in their care plans, and staff knew how to communicate effectively with people. Information could be translated to people's first language or larger print if required.

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.

This is the first time we have inspected the service and we have rated this key question Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The registered manager understood their regulatory requirements, including displaying the CQC's rating of performance and submitting legally required notifications to CQC. Legal notifications had been submitted and appropriate actions had been taken to safeguard people. However, there had been a delay in submitting these. The provider told us systems and processes had been implemented to ensure legal notifications were submitted to CQC without delay.
- The management team had not identified when mental capacity assessments and best interest decisions had not been undertaken. The registered manager told us these would be undertaken following the inspection. Further training was planned for the management team in relation to the MCA, to enhance their skills in undertaking MCA assessments and best interest decisions.
- Staff were clear about their roles and responsibilities towards the people they supported and felt listened to by the registered manager. They had regular supervisions which ensured they provided the care and support at the standards required.
- Most people knew who the manager was but told us the manager was not always available to respond to their concerns. One person told us, "I can't get hold of them [registered manager]." A relative told us, "[Registered manager] is never there and I cannot get hold of [Name]." A staff member told us, "Sometimes there is a lack of communication, sometimes the office doesn't know what's happening."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people.

- People told us their care was not always delivered at the time they needed it. People said, "The service doesn't run smoothly as it should do"; "I would just like the time of all my visits to be consistent" and "I would just like a service that is good quality and reliable seven days a week… They [service] have some really good carers working for them, who go the extra mile to make sure we are looked after and happy, but on the days when they don't work, it can feel like a completely different service looking after me."
- The management team had reviewed care plan documentation to ensure these were more person centred, and were updating all care plans at the time of the inspection. Staff had received training on person centred principles of care.

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

- The provider was open and honest with people when things went wrong and ensured open

communication with people, their relatives, staff and outside agencies.
● The provider was aware of, and there were systems in place to ensure compliance with, duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.
● Staff knew about how to whistle-blow and knew how to raise concerns with the local authority and the Care Quality Commission (CQC) if they felt they were not being listened to or their concerns acted upon.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● A survey had been undertaken to seek people's feedback of the care received. This identified people were not always satisfied with complaints outcomes, late calls and staff not staying for the duration of their call. The management team had implemented an action plan to address these concerns. This included increasing the frequency of telephone feedback calls, auditing complaints monthly and reviewing call times daily to identify and address themes and trends. These systems needed to be sustained and embedded in practice.
● Staff feedback was collated during supervisions, team meetings and from surveys. Records showed the service was responsive to staff feedback. For example, staff requested dementia training. This was being sourced by the service.

Continuous learning and improving care
● The service had identified areas for improvement and had implemented an electronic record keeping system for rota management. Staff could access this remotely via a secure mobile device. This system enabled the management team to have a live view of staff whereabouts and to identify missed calls or late calls for these to be addressed. Staff gave positive feedback on this system, one staff member told us, "Since we got [electronic system] I can tell people who is coming next."
● Regular audits were undertaken on medicines, complaints, staff files, accident and incident reporting and call times. The provider had identified areas for improvement and were acting to address these. Quality assurance visits were undertaken to people's homes to check for example; the safety of the environment, whether documentation was completed correctly, and medicines stock.
● The provider was committed to supporting staff to develop in their roles. A staff member told us, "I have completed the care certificate and am due to start an NVQ in care." An NVQ is a work-based qualification which recognises the skills and knowledge a person needs to do a job.

Working in partnership with others
●The provider and registered manager worked closely with the local authority commissioners and safeguarding authority to ensure the service developed and people remained safe.
● Staff worked closely with other health professionals such as speech and language therapists, community nurses and GPs which enhance the health and well-being of people.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service was not compliant with the requirement of the MCA to assess whether a person has capacity to agree to care and treatment and consider what is in a person's best interests.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not effectively deployed to ensure people's care was delivered at the time they needed.