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?	**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

The inspection site visit took place on 18 June 2018 and was announced. This service is a domiciliary care agency. It provides personal care to adults living in their own homes. One hundred people were receiving the regulated activity of 'personal care' at the time of our inspection visit. The site visit was carried out by two inspectors.

The service did not have a registered manager. However, a manager from another Universal Care Services branch, who is registered with us for the Corby branch, was covering at Coleshill. This manager has applied to become registered with us for Coleshill as well, though on a temporary basis, whilst a new manager is recruited.

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.

At the last inspection the service was rated 'Requires Improvement' overall, with the safety of the service being rated 'Inadequate.' We identified four breaches of the regulations. The breaches of the regulations related to medicines not always being administered safely and as prescribed. The provider had not always recorded or acted on complaints received about the service. The provider had not ensured there were enough skilled and appropriately trained staff to meet people's needs safely. The provider had not ensured staff were properly deployed to meet people's needs safely. 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.

We asked the provider to send us a report that said what action they were going to take to make improvements. A detailed report was sent to us and we have been monitoring the service since our last inspection.

At this inspection we found some improvements had been made, though these were insufficient to meet the requirements of the regulations. We identified two continued breaches of the regulations. The overall rating given to the service continued to be Requires Improvement.

People, relatives and care staff felt some improvements had started to be made from February 2018 onwards, when a new management structure was put into place by Clece Care. Most people told us there was greater consistency with the care staff that undertook their care calls now. People and their relatives gave us mostly positive comments about their care staff. Staff felt more able to raise issues with the manager and deputy manager than previously. However, further improvements were needed in all areas. People, relatives and staff were in agreement further improvements were needed and many comments made to us focused on office staff and their role, such as communication, needed improvement.

There was some improvement with systems that checked the quality of the service provided to help it improve now being in place and used. However, these were not always effective. The provider had not ensured staff undertaking audits had the necessary skills to implement improvements when actions needed were identified.

Some improvements had been made to the systems designed to ensure safe administration of medicines. However, these improvements had not been fully implemented to everyone supported by care staff with their medicines. Some people did not have the new, improved medicine administration record. This meant some people continued to be at risk from medicines not always being administered as prescribed because their administration record was not detailed. Some medicine records had signature gaps and action had not been taken to ascertain whether the medicine had been given or not.

People's needs had been assessed, however potential risks of harm or injury to people were not consistently identified.

Actions had not been consistently taken by the provider following a serious incident of an accidental house fire. The fire occurred outside of the agency's care calls, during March 2018. Timely action had not been taken to ensure risks to people currently using the service, from potential fires, were assessed and actions taken to minimise those risks.

People had experienced missed and late care calls and did not always find it possible to contact on-call staff when the office was closed.

Care staff understood the importance of recording accidents and incidents. However, accident and incident reports were not consistently logged at the office and there was no overall system in place for accident analysis and actions were not always taken to minimise the risks of reoccurrence.

Some improvements had been made to how complaints were handled.

Staff understood their responsibilities to protect people from the risks of abuse. Staff had been trained in what constituted abuse and would raise concerns under the provider's safeguarding policies. The provider checked staff's suitability to deliver care and support during the recruitment process.

Staff had received training in the Mental Capacity Act 2005 and worked in line with this to promote people's best interests. Staff offered choices to people and gained consent before, for example, supporting them with personal care.

There were enough staff employed to undertake care calls to people. However, people did not always receive their care calls at the agreed times because care call scheduling did not always allow staff sufficient travel time between calls. The call monitoring system was not effective in identifying missed or late calls to people.

Improvements had been made to ensure staff received training and used their skills, knowledge and experience to, overall, provide effective and responsive care. Further plans were in place to refresh care staff skills.

People were supported to eat and drink enough and care staff left people with drinks when needed.

We found continued 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?

Requires Improvement

The service was not consistently safe.

Systems to check medicines were given safely were not always effective. People had continued to experience missed or late calls and experienced difficulties with office staff communication about their care calls. Risks had not always been assessed. Where a risk had been identified, actions had not always been taken to minimise those risks. Staff had been safely recruited and there were sufficient numbers. Staff were aware of safeguarding procedures and knew what action to take if they suspected abuse. The manager understood their role in reporting safeguarding, though local authority investigation requests were not always responded to by the given date.

Is the service effective?

Requires Improvement

The service was not always effective.

Care staff worked within the principles of the Mental Capacity Act (MCA) 2005 when undertaking personal care tasks. However, managers did not ensure staff consistency included people's appointed power of attorneys when they should have in line with the remit of the MCA. Staff were inducted and trained when they joined the service. Staff supported people to eat and drink. Staff liaised with health care professionals on behalf of people.

Is the service caring?

Requires Improvement

The service was not always caring.

The provider and office staff responsible for care staff call schedules had not done all they could to promote a caring approach. People gave mixed feedback about their care staff. Most comments to us were, overall, positive. People were involved in their care planning. Staff knew how to promote people's independence and how they liked tasks undertaken.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People knew how to raise concerns and complaints and these were recorded and responded to. Improvements were not always sustained and people experienced similar concerns again. Most people's care plans were personalised and contained the information they needed, though this was not consistent.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Some quality monitoring systems were in place to identify any areas needing improvement, but these were not effective. The provider had failed to make the improvements needed to ensure people received a good service. The provider had not taken action to mitigate risks. People did not have confidence in the systems of communication with office staff or management.

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.

This comprehensive inspection took place on 18 June 2018 and was announced. This was to ensure the manager and staff were available to talk with us when we visited. The inspection was undertaken by two inspectors.

Prior to our site visit, we made telephone calls to people and their relatives to gain their feedback on the service they received from Universal Care Services, Coleshill.

Universal Care Services is a part of a larger company; Clece Care, though continues to operate as Universal. This service is a domiciliary care agency. It provides personal care to mainly older adults living in their own homes. Not everyone using the service receives the regulated service of personal care. Some people had 'cleaning' or 'shopping' visits. CQC only inspects the personal care service provided to people, that is help with tasks related to personal hygiene and eating. Where personal care is provided to people, we also take account of any wider social care provided.

Prior to our inspection visit, we reviewed the information we held about the service. We reviewed statutory notifications sent to us from the provider. A statutory notification is information about important events which the provider is required to send us by law.

We looked at information shared with us by the local authority commissioners. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

One local authority told us they had stopped placing people with this agency in September 2017 due to concerns about the services provided. The local authority found some improvements had been made and removed this stop in December 2017. However, their stop was re-imposed on the agency again in January 2018 due to further concerns. These concerns included large numbers of missed visits to people by the agency.

We did not ask for a Provider Information Return (PIR). This is information that we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. 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.

As part of our inspection we had telephone conversations with 15 people and seven relatives. During our inspection visit, we spoke with 12 care staff, the operations manager, the compliance manager for Universal Care Services and the manager of the Coleshill Universal Care Services branch. We also spoke with the operations director for Clece Care, and the head of clinical governance for Clece Care.

We reviewed 10 people's care plans, daily records and medicine administration records. This was so we could see how their care and support was planned and delivered. We also looked at other records, these included three staff recruitment files, the provider's quality assurance audits, missed care call records and records of complaints. This was so we could see how the manager and provider assured themselves people received a safe, effective quality service.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in September 2017, we found medicines were not administered safely or as prescribed, and systems designed to ensure the accurate administration of medicines were not effective. There were not enough staff to keep people safe or to respond to their needs. We rated the safety of the service as 'Inadequate.' We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as a result.

At this inspection, we found some improvements had been made but these were insufficient to meet the regulations. The deputy manager showed us a new, improved medicine administration record that they had implemented for some people. We saw this clearly listed prescribed medicines and instructions were clear. However, this improvement had not been consistently implemented and this meant there were variations of medicine administration records being used for people. Some of which lacked detail about people's prescribed medicines and instructions on administration were unclear. This meant some people continued to be at potential risk of their medicines not being administered in line with the prescribing instruction because improvement had not been consistently implemented by the provider. We gave a rating of Requires Improvement.

We discussed concerns we identified with five people's medicine administration records with the manager and deputy manager. For example, one person had, on one day, been given a 2.5mg dose of their blood thinning medicine instead of 2mg and following this error, there was no evidence of medical advice being sought .

Some people's medicine records had not been signed by staff to say whether medicine had been given. For example, one person's MAR recorded no signature for one medicine on both 10 and 11 March 2018. An audit completed 19 March 2018 identified this, but the only action recorded was 'no name – find carers on shift and do supervision.' There was no evidence of any action taken to seek medical advice, or that the gap in signatures had been raised by care staff who administered medicines immediately following these dates.

This was a continued breach of regulation 12 (1) (2) (g) HSCA (RA) Regulations 2014 Safe Care and Treatment

People's care plans included risk assessments, however, these did not always provide staff with enough information to keep people safe and actions had not always been taken when risks had been identified.

The provider had co-operated with a West Midlands Fire Service (WMFS) serious incident review following a fatality of a person in an accidental house fire. The fire occurred outside of the agency's care calls, during March 2018. Key findings and recommendations from WMFS had been shared with the provider and others, including the local authority. This was to create an awareness of partnership working with WMFS and offering a referral to people for safe and well visits, from the fire service, when identified by providers of care services, as being at potential risk.

We found where people were at increased risk of being harmed by fire, for example where they chose to smoke cigarettes, this had not always been assessed by the provider, to reduce the risk. One person's care plan (dated 1 March 2017) identified they smoked. In the 'risk assessment' section of the care plan, fire was identified as a risk, but the only note made to reduce or address the risk was 'has smoke alarms.'

One member of care staff told us one person they supported had 'some burn marks on their clothing' and 'sometimes they felt asleep in their chair.' This staff member told us they had reported their concerns to office staff several months ago but to their knowledge no review had taken place. There was no record of this concern being raised and no risk assessment review or liaison with other agencies such as the fire service who would have offered to undertake a home visit or provide fire retardant equipment.

Care staff told us about another person who chose to smoke and also used prescribed oxygen to help them breathe. This person's care plan recorded they smoked, but there was no record of them using oxygen. Neither was there any recorded risk assessment to assess or reduce the risk of fire relating to smoking and oxygen use. One care staff member told us, "This person falls asleep and when I arrived one day recently, they had fallen off the sofa onto the floor." This posed a significant risk to this person and others.

One person had been assessed as at 'very high risk' of developing sore skin because they were unable to re-position themselves and spent 24 hours each day in bed. This person had been provided with a special airflow mattress and hospital style bed by community health services. On 24 May 2018, staff had recorded this person's airflow mattress was 'not working correctly.' There was no record of any action being taken to address this. On 26 May, this person was recorded as having sore skin. We discussed this with the manager and they told us this person's airflow mattress was now working and had been checked by their visiting community nurse. However, there was no record to show how long the airflow mattress had not been functioning correctly, which posed risks to this person's skin integrity.

We saw stocks of gloves were available at the office and one care staff member said, "I've known the deputy manager spend time bringing gloves to staff if needed at people's houses." However, people did not consistently feel protected from risks of cross infection. One person told us, "My carers offer to prepare my food, but I won't have them doing that. They are wearing the same gloves they've had on to clean my commode."

Another person told us, "Staff don't wash their hands here, they tell me they have their own anti-bacterial wipe." This meant that whilst staff could collect personal protective clothing (PPE) from the office when needed and used it, some people's perception was that hand-washing did not always take place as often as it could.

This was a breach of regulation 12 (1) (2) (a) (b) HSCA (RA) Regulations 2014 Safe Care and Treatment

The deputy manager gave us an example of how learning had taken place and following liaison with the fire service, one person had been provided with a fire-retardant cloth and rug following a safe and well check from the fire service. However, other people at potential risk had not been offered referrals to the fire service nor had risk assessments always been undertaken.

Following our feedback to the manager and Clece Care management, we were told immediate action would be taken. This included undertaking risk assessments for people to ensure appropriate actions had been taken to minimise potential risks of harm and injury to people.

We spoke with staff and asked how they protected people from the risks of potential abuse. Staff had

received safeguarding training and understood what abuse was and how to report any concerns. One staff member said, "If I was concerned about someone, I'd report it straight away to the manager."

The provider kept records of all safeguarding incidents that had been reported to the local authority. These showed that, generally, the provider had liaised with the local authority and investigated concerns as and when requested. However, the local authority had written to the provider regarding one safeguarding incident and had requested a response by 24 May 2018. No response was included in the records. We raised this with the deputy manager who later showed us an undated note they stated they had sent to the local authority. However, the local authority confirmed to us that they had not received a report as requested and had made a further request to the provider on 6 June 2018.

The registered manager and the deputy manager understood their role and responsibility to alert the authorities should an adult be at risk of harm or abuse. However, investigation reports were not always received by the local authority as requested.

Prior to this inspection visit, anonymous information had been shared with us telling us about a high level of missed care calls during December 2017 and January 2018. One local authority had investigated and re-imposed a placement stop in December 2017 due to their concerns that included missed care calls to people.

On this inspection, we asked to see records of missed care calls. The provider only had records that ran from 1 May 2018 to 1 June 2018. When we asked for records pre-dating this, we were told these were not available because they did not have them. From the missed care-call records we looked at, we saw during this time-period, there were 11 missed calls in total, 5 were attributed to 'carer error', with the remainder attributed to 'office error.'

People made many negative comments to us about their care call times. One person told us, "My morning call is meant to be 08.30 – 09.30, but they arrived at 13.30. I should then have a call between 16.30 and 18.30, but they came at midnight."

Some people paid for their own care calls and had been charged when they had either cancelled calls or care calls had not taken place as planned. One person told us, "They knew I was in hospital and I was still charged for calls. Also, when they missed my calls, I was still charged." Another person told us, "A few weeks ago, I cancelled a call and the carer still turned up and told me they had to stay for half an hour. I was feeling unwell and just wanted to go to bed. They (office staff) don't listen half the time."

We were assured by the manager, that where errors had been made by care staff, action was taken including discussions in one to one meetings where it was made clear to staff what the expectations were.

The provider acknowledged there was currently no way of missed calls being automatically identified to staff during out of office hours, so timely action could be taken to ensure people were safe. We asked the registered manager how they would know a call had been missed, and they told us they would currently be reliant on a person or a family member contacting them to advise of this. They acknowledged that, if a person lived alone and could not use a phone for example, they had no reliable way to identify missed care calls. However, the provider was actively looking for solutions to this so their electronic systems were more effective. The compliance manager told us they would be resolving this problem before the end of June 2018; by creating log-in access to the call monitoring system for on-call staff to monitor.

The provider's recruitment process ensured risks to people's safety were minimised, as they took measures

to try and ensure new staff were of 'good character.' One staff member told us, "I started here four months ago. I had an interview, gave references and they did a DBS on me." The Disclosure and Barring Service (DBS) is a national agency that keeps records of criminal convictions.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in September 2017, we found the service was not always effective. New staff were not always inducted effectively into the service and checks were not in place to ensure new and existing staff working in line with the provider's expectations. We rated this key question as Requires Improvement.

At this inspection, we found some improvements had been made which were sufficient to meet the requirements of the regulations. However, further improvements were needed to ensure the service was fully responsive to people's individual needs. The rating continues to be Requires Improvement.

Improvements had been made to new staff being inducted into the service. One care staff member told us, "I started working for Universal about four months ago. I had a four-day induction of training before I started care calls. I did some shadowing shifts with another staff member. Yes, I found it really-good, there was enough information."

Some longer standing staff said they had received additional refresher training since their induction. However, others said they had not completed any further training since their induction. The operations manager told us two training staff members had recently been recruited. They showed us plans for further training and updates that were scheduled to take place.

Staff spoken with told us they had not completed or been enrolled on the Care Certificate, however records showed some of those staff had, in fact, completed this with the provider and staff had forgotten this when we asked them about it. The operations manager told us some care staff had completed the Care Certificate and improvement plans for training included further care staff being assessed for the Care Certificate. 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.

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.

The registered manager and the deputy manager both demonstrated they understood their role and responsibility under the MCA. However, they did not consistently ensure all staff worked within the principles of this.

Care records showed where people had appointed a power of attorney for financial and / or health and welfare decisions this was recorded. One care plan showed one person's close friend, who they had appointed their power of attorney (POA), had been involved in this person's care planning. However, one relative who was POA to their family member, shared a concern with us. They told us a staff member had

visited their family member last weekend and asked them to sign a document that was also back-dated. This had caused their family member to become anxious about what they had signed. It emerged this document related to a care review which the POA had not been invited to take part in. We discussed this with the manager, who agreed this should not have happened and confirmed they were investigating this recent incident.

Care staff told us they asked for people's consent before supporting them with personal care. One care staff member told us, "I explain why I am there and what the care plan tasks are. I always talk to someone when supporting them."

People's needs were assessed and documented before they started using the service. Records showed staff collected a range of information about people so they could meet their needs.

Care staff told us they had one to one supervision meetings where they could discuss issues relating to their work and any developmental needs they had. Some care staff told us they had team meetings and others said they had never had any. When we asked to review team meeting minutes, the records only related to office staff. When we asked about communication with care staff, the deputy manager told us they phoned them or sent a text or email message. The deputy manager confirmed to us that records of communication were not always kept, despite messages having included important issues such as people's health and safety.

Care staff told us they were responsible for preparing some people's food and drink. One care staff told us, "One person I support cannot get anything for themselves, so I always make sure they have four bottles of drink left with them and a sandwich." Another care staff said, "We offer choices to people about what they would like to eat or drink, based on what they have in stock in their own kitchen." Care staff told us if they had any concerns such as a lack of food in a person's home or if they felt a person was not eating or drinking enough, they would report this to the deputy manager.

Care staff told us they would report any health concerns to the manager if needed. One care staff member said, "We'd contact a person's GP on their behalf if needed or contact office staff if we had any concerns." One care staff member told us they supported someone who used a catheter to drain urine. They said, "It can become blocked, so we contact the district nurse. The nurse's details are in the person's home because they visit to make checks anyway. They are very good and would come out the same day to check."

Requires Improvement

Is the service caring?

Our findings

At our last inspection in September 2017 we rated this key question as Requires Improvement. People and their relatives had spoken positively about care staff they knew well, but were not positive about care staff not familiar to them. We had negative comments made to us about the provider's approach not being caring. People and their relatives had also described office staff negatively to us, with communication being described as 'rude'.

At this inspection we found improvements were still needed from the provider and office staff to enable care staff to have a consistent caring approach. The provider and office staff responsible for care staff call schedules had not done all they could to promote a caring approach. The rating for this key question continues to be Requires Improvement.

People gave us mixed feedback about their care staff. We received some very positive comments that included people being 'very happy with the care staff' and 'they make me feel at ease, they are kind and don't rush me.' Another person described their care staff as 'brilliant.' One relative told us, "I cannot fault the girls (care staff) that come, they are lovely." However, this relative went on to tell us about their experiences with office staff and care call scheduling that was negative and left them 'fuming'.

Care staff told us they had been informed by office staff, responsible for scheduling care calls, that is was acceptable to leave early 'by four or five minutes' from calls, to reach their next visit on time. Most care staff told us they did not do this but started calls early in their own time, so as not to cut care calls short. Some staff said they did shorten visits to people, which meant people did not receive their allocated time.

Where care calls were scheduled with insufficient travel time for care staff, and they felt pressured, this potentially explained to us why some people and staff felt 'rushed' during visits.

Overall, people and their relatives were involved in planning their care and support. However, one relative told us that despite them having made the office staff aware that they held power of attorney for their relative, they had not been involved in their family member's care plan.

Staff knew how to maintain people's privacy and dignity, although this did not consistently take place. Office staff scheduling care calls to people did not always respect people's preferences for their care staff to be a specific gender. For example, one person told us, "I've had men shower me. It's out of order. It's not right. I felt degraded."

Staff told us some fifteen-minute care calls were to support people to use the toilet. One staff member said, "I try to give as much privacy as possible by going to another room."

Staff promoted people's independence. One staff member told us, "One person I support wants to maintain their ability to stand and walk, so we give minimal support to them, so they maintain their abilities." Another staff member said, "I try to encourage one person to select their clothing for the day."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in September 2017, we found complaints made to the provider were not always recorded or responded to. We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as a result. People and their relatives had also shared their concerns with us about a lack of consistency in the care staff undertaking their care calls. This led to some people feeling anxious. We rated this key question as Requires Improvement.

At this inspection, we found some improvements had been made which were sufficient to meet the requirements of the regulations. However, further improvements were needed to ensure the service was fully responsive to people's individual needs. The rating continues to be Requires Improvement.

Improvement had been made to record written complaints. Records showed six complaints had been made since January 2018, and these had been investigated and responded to. One person, who preferred female carers, told us, "Once two male carers came to my night time care." This person told us that following them raising this issue, it did not happen again.

People's complaints and concerns, however, were not used to improve the quality of the service. People did not always feel issues they raised were resolved because the same arose again. For example, people and their relatives told us they had complained about late and missed calls but these issues persisted.

As a part of our conversations with people, we were made aware of two complaints that had been made verbally that were not recorded. The manager confirmed to us that verbal complaints should also be logged. The compliance manager took immediate action following our inspection visit to remind all staff of the verbal complaint form to use and the importance of this so that issues could be addressed.

People told us that, overall, they were happy with their regular care staff, who knew them and met their needs. One person told us, "I can't say a bad word about the girls (carers), I can't fault them." However, people expressed some concern about staff changes and one person said, "They can't keep the staff." Another person said, "My two staff are leaving, I don't know who will come."

Care plans were, overall, personalised and contained information for staff to follow. A page entitled 'This is Me' gave care staff a profile about people and their needs. Some personalised information enabled staff to build a rapport with people. For example, one person's care plan recorded they liked to watch and talk about football and recorded which team they supported, as well as particular players they admired.

There was information about how tasks should be undertaken during care calls for staff to refer to. Staff told us they felt care plans contained enough detail. One care staff member said, "Generally I go to the same people, so once I get to know them, I don't need to refer to the care plan."

There was some information in people's care plans, for example on whether they followed a particular religion.

One relative, however, told us their family member's care plan was "75% incorrect." This relative told us they believed the care plan may have been 'cut and pasted' and hence the incorrect information, which stated their family member lived with dementia, when in fact they had a totally different health condition. This relative added they had made the manager aware of this and a review had been arranged to ensure the care plan contained the correct information.

We found examples of when care was personalised and responsive to people's individual needs. This included where people's needs had changed and the provider had taken effective action to involve other professionals in order for people's needs to be met. For example, care staff had reported one person was finding it more difficult to use their stairs, and that they were becoming generally more disorientated and confused. This person's electronic care records kept by the provider showed they had escalated these concerns to commissioners from the local authority so they could be addressed.

Staff, however, were not consistently responsive to people's needs. For example, one person told us they had sustained a fall in their home following their care call. Despite this being 'three or four weeks ago' this person told us they were still in pain and their hip was swollen. This person said care staff had 'written this in the book' (daily notes in their home). We discussed this person with the manager and deputy manager, who told us they had not been made aware of this person's pain and potential injury. Immediate action was taken to arrange a GP home visit for this person. Following our inspection visit, the deputy manager informed us the GP had visited this person and found bruising that would heal from rest.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in September 2017, we found the service was not consistently well led. Quality monitoring systems that were in place, 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 risks 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 told us had deteriorated from June to September 2017. We rated this key question as Requires Improvement. We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as a result.

At this inspection, we found insufficient improvements had been to meet the requirements of the regulations. We found some quality monitoring systems were now used, though these were not effective. People and their relatives did not consistently have confidence in 'office staff' communications or in management to improve issues such as care call scheduling. Overall, staff felt there had been improvements though further improvement was needed, for example in their care call information. We found a continued breach of the regulations. The rating continued to be Requires Improvement.

We asked to look at quality assurance monitoring systems, such as audits, to assess how the provider monitored the service and took action to improve. Medicines audits had been completed and identified some of the same concerns we found. However, no action had been taken to address the issues or to reduce the risks of reoccurrence.

Although the provider had recognised their call monitoring system was not fully effective, and missed and late calls to people had occurred, no effective action had been taken to make improvements. The manager confirmed to us that some people lived alone and were unable to access the telephone themselves or meet any of their own needs. Despite this, timely action had not been taken to make improvements and whilst we found the frequency of people experiencing missed or late calls had reduced, since February 2018, these still occurred. This continued to potentially leave people at risk in terms of their wellbeing.

Some care staff told us they continued to not have enough time allocated to them between their care calls to people. For example, one staff member told us, "I have five minutes allocated between two visits to people and the distance between these people's addresses is at least a fifteen or twenty-minute drive. I can't fit in the visits unless I use my own time as well."

Rota scheduling did not always support care staff to consistently have a caring approach or implement their learning from equality, diversity and human rights training they had undertaken. One person told, "One of my carers tends to rush me, they say 'come on, we've only got two minutes left' (of the allocated visit time)". Another person told us, "I had one carer that was rough and was in and out in ten minutes. They shorten the care calls." One person told us, "I don't think the problems are due to the care staff, it's the office and management."

The provider and manager did not undertaken checks on staff providing an on-call service to ensure people

consistently received the service the provider hoped for. People told us they found it very difficult and sometimes impossible to contact staff when the office was closed. Despite people trying the on-call out of office hours, people told us their calls often went unanswered. The manager told us they were aware of some people's concerns. They said phone calls may have gone unanswered if the on-call person was covering a care call themselves. However, the manager had not made any 'spot- check' calls to the on-call telephone number themselves to assure themselves it was answered promptly or voicemails were returned in a timely way.

Timely action had not been taken, by the provider, to ensure risks to people, from potential fires, were assessed and actions taken to minimise those risks.
We asked the manager and deputy manager to evidence how they had shared learning, with staff, following on from the serious incident (March 2018). The deputy manager told us they had phoned staff, however, there was no record of this. Care staff confirmed they had received calls but this was to ask which people they supported smoked cigarettes and to be told they should not buy cigarettes for people if they did their shopping.

The provider had not arranged any training update for care staff to include fire safety awareness, how to escalate concerns about risks of potential harm, and how these should be acted upon once received by office staff. There had been no audit of care records to determine which people may potentially be at risk of harm or injury from fire. A review of people's risk assessments had not been undertaken to determine whether further actions were needed to, such as to offer people a safe and well referral to the local fire service.

This was a continued breach of regulation 17 (1) (2) (a) (b) HSCA (RA) Regulations 2014 Governance

Staff told us they enjoyed supporting people but had concerns about their 'zero-hour' employment contracts. One staff member told us, "I'm leaving because I just don't get the hours." Another care staff member said, "It's a real problem. People get to know one carer and then they leave. It's because we don't know what hours we will get one week to the next." The operations director confirmed they had experienced a high-turnover of staff and this was why people had experienced changes to those undertaking their care calls. The manager added they were aware of the 'zero-hour' staff contracts impacting this. They told us this was being 'looked into' so that improvements could be made to the consistency of people's care staff.

The service had not a registered manager in post registered with us since July 2017. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

The provider confirmed that they were currently advertising for a new manager for the Coleshill branch and once recruited, this person would apply to become registered with us. As a temporary measure, a manager from another Universal Care Services branch, who is registered with us for the Corby branch, has been covering Coleshill since February 2018. This manager has applied to become registered with us for Coleshill as well, though on a temporary basis, whilst the new manager is recruited.

The manager, deputy manager and compliance manager were unable to tell us their clearly defined roles regarding responsibilities for quality assurance. When we asked to look at accident and incident analysis, complaints analysis, feedback quality assurance surveys from people and their relatives, these could either not be located or had not been completed.

The provider had failed to assure themselves that branch staff focused on the improvements needed following our previous inspection and insufficient oversight had been in place.

Universal Care Services has a website which provides information about their services and a link to their latest CQC rating. The last inspection rating was displayed within the office.

Following our feedback on the day of our inspection visit, the provider told us a they were imposing a stop on accepting any further packages of care until improvements were made. The provider confirmed this in writing to us and sent us action plan detailing what immediate actions they had taken.
Immediate actions included communication with care staff about escalating any concerns they about people they supported, fire safety and planned training.

The detailed action plan sent to us, covered processes and system improvements to be made, by who and a time scale for implementation. Most had implantation dates for June 2018 and completion by the end of July 2018. Clece Care's head of clinical governance quality and compliance made a commitment to weekly meetings with key staff from the Coleshill branch. The purpose being to set actions, monitor these and follow up to ensure completion of improvements.

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 The provider did not ensure the proper and safe management of medicines. The provider did not ensure care and treatment was provided in a safe way for people. Risks to the health and safety of people had not always been assessed. Risks had not always been mitigated.

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 17 HSCA RA Regulations 2014 Good governance The provider did not always assess, monitor, improve the quality and safety of the services provided in the carrying on of the regulated activity. The provider did not always assess, monitor or mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.

The enforcement action we took:

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