UK Care Team Ltd

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Inspection report

1000 Great West Road
Ground Floor, Suite D, The Mille
Brentford
Middlesex
TW8 9DW

Tel: 02031433555

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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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We undertook an announced comprehensive inspection of UK Care Team Ltd on 29 and 30 January 2018. We gave the provider two working days' notice as the location provided a service to people in their own homes and we needed to confirm a manager would be available when we inspected.

This service is a domiciliary care agency. It provides personal care to people living in their own homes in the London Borough of Ealing. It provides a service to both younger and older adults. Not everyone using UK Care Team Ltd receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of the inspection there were seven people receiving support from the service of which six received support with personal care

At the time of the inspection the manager was in the process of applying to the Care Quality Commission to become the registered manager for 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 had a process in relation to the administration of medicines but information indicated people did not always receive their medicines as prescribed.

Risk assessments were now in place to assess general risks but risk management plans were not in place for specific risk to provide care workers with appropriate guidance to minimise risks.

The provider had a process in place in relation to the Mental Capacity Act 2005 but was not always working within the principles of the Act to ensure people could consent to their care or that decisions were made in their best interests.

Care plans did not always provide accurate and consistent information for care workers as to how they should provide support to meet people's care needs.

The provider had a range of quality assurance processes to monitor the service and identify areas for improvement but some of these were not effective.

We found breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were breaches of Regulation 9 (person-centred care), Regulation 11 (need for consent), Regulation 12 (safe care and treatment), and Regulation 17 (Good governance). You can see what action we told the provider to take at the back of the full version of the report.

The provider had a robust recruitment process to ensure new staff had the appropriate skills and knowledge and were suitable to work within the service.

The provider had systems for the recording and investigation of incidents and accidents, complaints and safeguarding concerns to identify any trends or required actions.

Care workers had completed the mandatory training identified by the provider as well as regular supervision and appraisal meetings.

Relatives were happy with the support provided and felt the care workers were kind, caring and treated their family members with respect.

The provider had a complaints process in place and people knew what to do if they wished to raise any concerns.

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

Some aspects of the service were not safe.

The provider had a process in relation to the administration of medicines but information indicated people did not always receive their medicines as prescribed.

Risk management plans were not in place to provide care workers with the information to enable them to mitigate these risks when providing care.

The provider had a robust recruitment process to ensure new staff had appropriate skills and knowledge.

Incidents and accidents were recorded and reviewed to identify if there were any trends and actions required to prevent reoccurrence.

Is the service effective?

Requires Improvement

Some aspects of the service were not safe.

The provider had a process in relation to the administration of medicines but information indicated people did not always receive their medicines as prescribed.

Risk management plans were not in place to provide care workers with the information to enable them to mitigate these risks when providing care.

The provider had a robust recruitment process to ensure new staff had appropriate skills and knowledge.

Incidents and accidents were recorded and reviewed to identify if there were any trends and actions required to prevent reoccurrence.

Is the service caring?

Good

The service was caring.

Relatives were happy with the care provided and they felt the

care workers treated their family members with dignity and respect.

Care plans identified the person's cultural and religious needs as well as the name they preferred care workers to call them.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

Some of the care plans identified how people wished their care to be provided but the records had not been reviewed if a change to the person's supports needs had occurred. Other records of care were focused on care tasks and not the person.

The provider had a complaints process in place and people knew what to do if they wished to raise any concerns.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

The provider carried out audits to monitor the quality of care provided but some of these did not provide appropriate information to identify areas of the service requiring improvement.

People using the service and relatives provided feedback to the provider on the quality of the service.

Relatives and care workers felt the service was well-led.

UK Care Team Ltd

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 checked 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 29 and 30 January 2018 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available.

The inspection was carried out by one inspector.

Prior to the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information sent to us in the PIR and notifications we had received from the provider. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about.

During the inspection, we spoke with the manager and a director of the service. We also looked at records, including four people's care plans, three staff records, medicine administration records and records relating to the management of the service. We spoke with the relatives of two people using the service. We sent emails for feedback to six care workers and received comments from two care workers.

Requires Improvement

Is the service safe?

Our findings

The provider had a procedure for the management of medicines but we saw that medicines were not administered in line with identified good practice. During the inspection we looked at the medicine administration record (MAR) chart for one person. Care workers were not required to administer medicines for everyone who received support from the service.

The records for the person stated care workers should apply a new medicated patch to the person's skin daily and the location on the body should be changed each time the patch was replaced. There was no guidance for care workers as to the best location for the patch to be placed and a record was not kept as to the location of each patch. The person was also prescribed aspirin but the records did not indicate if this was to be administered when required for pain relief or if it had to be taken daily as an anticoagulant. The MAR chart for November 2017 indicated it had not been administered for a seven day period. The manager told us they believed the aspirin may have been prescribed as an anticoagulant and had not been administered as the supply had run out. We also saw the MAR charts indicated the medicated patch had not been administered for three days in November 2017 and for a period of seven days in December 2017. The manager confirmed this was also due to there being none available at the person's home. The care plan indicated the person's family were responsible for arranging for repeat prescriptions and ensure medicines were available. This meant the person had not received their medicines as prescribed.

We saw care workers administered the medicines for a second person but the MAR charts were not available. The manager told us the medicines had been changed recently and the MAR charts had not been collected from the person's home. The care plan indicated medicines should be administered as prescribed.

We saw the provider had risk assessments for the moving and handling of people who used the service, infection control and the working environment for care workers. Where risks or issues had been identified through the person's needs assessment, risk management plans were not in place to provide sufficient guidance for care workers as to how to reduce the possible risks.

We saw the risk management guidance provided to care workers for a person who lived with seizures indicated they should not intervene but did not identify how care workers should provide support for the person to maintain their safety.

The risk assessment for another person in relation to falls and trips stated to reduce the risk the care workers should identify any hazards in the home and complete an incident and accident form if the person fell. The person's needs assessment had identified they were at an increased risk of falls and used a walking aid but there was no risk management plan providing guidance for care workers in relation to their specific support needs.

We also saw the needs assessments of other people had identified a range of possible risks which included increased risk of pressure sores, malnutrition and infection as a result of a urinary catheter. Risk management plans had not been developed to provide care workers with guidance to assist them to reduce

any associated risks when providing care.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Relatives told us they felt their family member was safe when they received care. The provider had a process in place to investigate and respond to any concerns that were raised in relation to the care provided. The manager confirmed that no safeguarding concerns had been raised since the service was registered. The care workers confirmed they had completed safeguarding training as part of their induction and understood how to report any concerns.

The manager explained the number of care workers required to attend each visit was identified from the information provided by the local authority and from discussions with the person using the service and relatives during the initial assessment carried out before the care package started. This was also assessed when the care plan was reviewed or if the person's support needs had changed.

The provider had a process to record, investigate and review incidents and accidents. The manager explained a form would be completed including information about the incident and accident and any actions taken. During the inspection we looked at the records of one incident and accident and saw these were detailed and identified the actions taken in response to resolve any issues.

The service had suitable recruitment processes in place. The manager confirmed people applying to become care workers were required to provide the contact details of two references and their employment history for up to 10 years. Before they started to work for the service a Disclosure and Barring Service (DBS) criminal record check was carried out. During the inspection we looked at the employment records for three care workers and saw all the paperwork identified as required by the provider was in place. This meant that checks were carried out on new care workers to ensure they had the appropriate skills to provide the care required by the people using the service.

Relatives we spoke with told us the care workers did not always arrive on time for their visit but one relative said they did call to let them know the call would start late. Their comments included "They don't always get here on time. Sometimes no call if they are going to be late. I have complained once" and "Most of the time yes they are on time, sometimes they are late due to traffic." A care worker told us "I do have enough time to complete visits. I do not always have enough travel time because of slow buses on weekends and I request more travel time when necessary."

The provider had a computer based system used to allocate visits and monitor that visits were carried out at the agreed time. We looked at the electronic call monitoring system (ECMS) records for visits carried out over two days in January 2018. We saw the majority of visits were carried out with 15 minutes of the agreed start time and care workers had stayed for the full time of the visit. We also saw care workers were given appropriate travel time between each scheduled visit to enable them to spend the full time at one visit and arrive on time for the next call.

Care workers completed training for infection control as part of their induction and they were provided with appropriate equipment including aprons and gloves to use when providing support. An infection control risk assessment was completed as part of the care plan for each person.

Requires Improvement

Is the service effective?

Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

During the inspection we saw an assessment of each person's mental capacity was completed for a range of areas including choice of food, personal care and finance. The outcome of the assessment did not relate to a specific aspect of the persons care but provided a general assessment of their overall capacity to make any decisions. We saw the records for one person indicated they did not have capacity to make decisions about their care. A relative had signed the care plan to consent to care being provided but there was no indication that they had the legal authority to do this through a Lasting Power of Attorney (LPA).

The information from the local authority for another person indicated there were issues with their memory but the provider had not carried out any assessments of the person's capacity to consent to their care or ensured best interests decisions had been made in relation to their care. This meant the person's care was not being provided within the principles of the Act.

The above was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

An assessment was carried out to identify the person's support needs which were then used to develop the care plan and risk assessments. The manager told us whenever possible they met with the person and their relatives before the care package started to carry out the assessment but sometimes this was done during the first care visit. Information relating to the person's care needs was included as part of the paperwork provided by the local authority which was also used to develop the care plan.

Relatives told us they felt some care workers had more experience than others and the new care workers lacked some understanding and knowledge relating to the role. One relative said they thought some of them did not understand how everything needed to be done during a visit.

The manager explained new care workers completed the Care Certificate through an online learning system. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. There were additional face to face training sessions for safeguarding, medicines management and manual handling to assist the care workers understanding of the online module. During the inspection we looked at the records for three care workers and saw certificates

for each module of the Care Certificate with the date of completion.

New care workers completed shifts shadowing a senior care worker or completed visits with an experienced colleague and having their competency assessed before they started to provide care on their own. We saw feedback forms had been completed by the experienced care worker commenting on the suitability and competence of the new care worker.

Care workers would complete annual refresher training based upon the Care Certificate modules. We saw care workers had supervision meetings with the manager every quarter and records of the discussion were kept on their file. The care worker would complete an appraisal once they had been in their role for a year.

Care plans identified if the person required support from the care worker to prepare and/or cook a meal. It also indicated if the person's family were involved in providing support with meals. Care workers confirmed when it was identified in the care plan they supported the person by preparing meals.

The care plans included the contact information for the person's GP and the manager confirmed they would contact the GP, district nurse or specialist nurse if any concerns were raised by the care workers regarding a person's health. The manager told us they had visited people with the GP and specialist nurses to review the care they required.

Good

Is the service caring?

Our findings

The relatives we spoke with told us they were happy with the care and support provided by the care workers. They also said they felt the care workers treated their family members with respect and dignity when they received care. One relative said "They are reasonably quite OK but sometimes they are a bit late" and "They are always respectful to my family member. I am happy with the care we get." A care worker told us "I ensure the clients dignity is maintained by allowing them to make their own decisions and ensure privacy by closing the door when dealing with personal care" when asked how they maintained a person's dignity when providing care.

We received mixed responses from relatives when we asked if regular care workers carried out the visits so there was consistency. One relative told us "They don't change. Sometimes the morning care worker can come in the afternoon though" and another relative said "They change quite often. There are different ones."

We saw some of the care plans identified when the person could carry out care activities themselves and when they needed additional support from the care worker. Relatives confirmed the care workers helped their family member to be as independent as possible.

The care plans we looked at identified the name the person preferred to be called, their religion, cultural background and if this influenced the way care should be provided such as types of food. The person's preferred language was also identified in the care plan.

We asked relatives if they felt the information provided in relation to the care being provided was clear and easy to understand. One relative felt the information was clear while the other relative was unable to comment as apart from being sent the rota for care workers they felt they had received no other information. The manager confirmed an information pack was given to each person when they started to receive care in their home and rotas were sent out indicating which care workers would be visiting.

Requires Improvement

Is the service responsive?

Our findings

Relatives told us they were involved in discussions about how the care should be provided to meet the needs of their family member. Each person had a care plan which had been developed from the initial needs assessment. During the inspection we looked at the care plans for four people receiving support. We saw some aspects of the information relating to the care activities to be completed during each visit was task focused and did not identify how people wanted their care provided. For example in the care tasks section of two care plans there was a list of activities including phrases such as 'strip wash, hoisting, toileting and pad change' to describe what the care worker had to do during a visit. This meant the care records did not all have all the necessary information on how the person wished their care to be provided to support the care worker in delivering the care.

We saw care plans did not always provide accurate and consistent information for care workers to identify how they should provide appropriate care for the person. The care plan for one person indicated care workers needed to ensure a padded foot cover was in place when the person was seated or lying down. The records also stated the person had been prescribed a nutritional supplement drink to be taken every day. We saw that care workers had not referred to the foot cover being used or the nutritional supplement drink being given, in their record from each care visit. We asked the manager who confirmed the person did not need to use the foot cover or take the supplement drink but the care plan had not been updated. The manager said they had informed the care workers that visited that person of the change in support needs via an application on their mobile phone but had not updated the care plan or risk assessments. This meant the records identifying the person's support need did not provide care workers with up to date information.

We saw the information provided by the local authority for another person indicated the care workers should administer the medicines during the visits. When we reviewed the care plan we saw one section stated the person managed their own medicines and did not require support from care workers but other parts of the plan indicated the care workers should administer medicines. The information provided was therefore not consistent and did not provide accurate information for care workers.

Some of the daily records of support completed after each visit by care workers were also focused on the care tasks and did not provide a complete picture of the person during the visit in the records. We saw some care workers had used language when referring to the care provided which was not respectful to the person receiving support. We discussed this with the manager who confirmed they would speak with the care workers about use of appropriate words when describing care.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The manager told us they identified technology to help the care workers provide care as the care workers used a messaging application on their mobile phone to receive updates if there were any changes to the planned visits or to the care someone required.

The care plans did not include information about the person's end of life wishes. The manager explained that this information has not been included yet as they had not provided support for anyone requiring that stage of care.

The provider had a process to respond to complaints and relatives told us they knew how to raise any concerns relating to the care provided. One relative said "If there is a problem I would call the local authority." The manager explained if there was a complaint regarding the care provided the person would contact the local authority. The information was then passed to the provider so they could investigate and respond to the local authority within an agreed timescale. During the inspection we saw the records for one complaint which included copies of the investigation, the response to the local authority and the outcome indicating the person was satisfied with the response.

Requires Improvement

Is the service well-led?

Our findings

The provider carried out checks on the quality of the care provided but we saw the audits, which were carried out, were not effective in that these did not provide them with the appropriate information to monitor quality and make improvements.

The records of care completed by the care workers after each visit were reviewed monthly and were checked against the time recorded to the electronic call monitoring system (ECMS) information for the visits. The audits did not identify the issues noted in the report regarding the records being task focused and the use of inappropriate wording in describing the care people received.

As part of the review of the record of each visit the MAR charts were also reviewed monthly but this did not identify the areas where the information was not recorded in line with the NICE guidance.

The issue with the accuracy of the records identified during the inspection indicated the provider did not have systems in place to ensure consistency and accuracy of the care plans. Therefore they could not always ensure people received the appropriate care they required.

The provider did not have a robust system in place to monitor whether the rights of people were being upheld by making sure they were fully involved in making decisions about their care and could give consent to their care and treatment, before best interests decisions were made on their behalf

The above shows that the provider was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The incident and accident records were reviewed every quarter to identify if trends and if any actions were required to prevent recurrence.
Relatives commented they felt the service was well led, based on their experience. One relative said "They are much better than other services we have used. They appear professional and I have no major concerns."
Care workers also told us they felt the service was well-led. One care worker told us "Yes, management gives a listening ear to the staff."
People using the service and relatives could provide feedback on the quality of care provided. The manager confirmed a questionnaire had been sent to people using the service shortly before the inspection and they were awaiting the completed forms. Quality assurance review checks were carried three months after the start of the care package and then every six months. As part of these reviews the paperwork in the person's home was checked and they were asked for feedback on the care workers and the support they had received. We saw completed review forms and the feedback from people and relatives was positive.

The manager told us they sent out monthly memos to care workers to provide updated information on any changes to how care should be provided and any updated good practice. Care workers attended meetings every six months to discuss best practice and the manager said these would be held sooner if any concerns about how care was provided were identified. A care worker confirmed they received information from the

manager "I've had supervision after two months of working and my manager calls to update me on anything as well as [send] emails."

An information booklet was provided to people using the service which included the aims and objectives of the service, a charter of rights in relation to how care was provided and how they maintained the standards of care.

The manager had signed up as a dignity in care champion as part of the National Dignity Council scheme to enable them to provide care workers with current good practice in relation to maintain the persons dignity.

At the time of the inspection the manager was in the process of registering with the CQC. Apart from the six care workers who provided support for the people using the service the manager was responsible for all other management and supervisory roles at the service. The directors visited the service on a weekly basis from their Leicester office and supported with the auditing of records. The manager explained they were responsible for a number of activities including recruitment, training, supervision, assessment of a person's needs, development and review of care plans, covering visits in case of an emergency and being on call. The manager told us this resulted in some administration activities including updating records were sometimes missed.

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 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users did not meet their needs or reflect their preferences. Regulation 9 (1) (a) (b) (c)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person did always not act in accordance with the Mental Capacity Act 2005 where service users were unable to give consent to care because they lacked capacity to do so. Regulation 11 (4)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure care was provided in a safe way for service users in that they did not ensure the proper and safe management of medicines. Regulation12 (1)(2) (g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

The registered person did not have a system in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.

Regulation 17 (1)(2) (a)

The registered person did not have a process in place to assess the specific risks to the health and safety of services users and do all that is reasonably practicable to mitigate any such risks.
Regulation 17 (1)(2) (b)