Universal Care Limited

Universal Care - Beaconsfield

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Universal Care – Beaconsfield is registered to provide personal care and support to people in their own homes. 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 were not routinely and consistently protected from potential risks to their health and well-being as a result of their medical conditions. We found risk assessments were either lacking in detail or omitted altogether. For instance, people who had a diagnosis of diabetes did not routinely have a risk assessment in place.

Risk assessments contained conflicting information or did not provide adequate guidance for staff. We found risk assessments for people prescribed anticoagulant medicines routinely stated "Carers MUST call paramedics immediately if [Name of person] has a bad fall likely to cause internal bleeding, a nosebleed, cut or wound." No additional guidance for staff was available for what constituted a 'bad fall'. Risks assessments associated with people's dietary needs were not routinely effective and staff did not always follow the guidance.

People were placed at risk by poor medicine management. We found some people were given medicine by staff when they were assessed as "self-medicating". Staff had little information on when to support people with medicines prescribed for occasional use. We found staff failed to routinely record what medicine they administered, which could have led to people receiving more or less than prescribed.

The provider had failed to learn from previous concerns and did not fully investigate incidents, accidents or near misses. This had the potential for people to be out at continued risk.

Staff supporting people did not have up to date and accurate information available to them. This was due to delays in risk assessments or care plans being written or care plans being developed in the office without any communication with the person.

People had the potential to be supported by staff who had not been recruited safely. The provider failed to ensure all the required pre-employment checks were carried out.

People were put at risk from the current coronavirus as office staff who visited people in their own homes were not following government guidance on personal protective equipment and social distancing.

Feedback we received from people and their relatives was in the main positive. Comments included, "I'm very happy with the carers, I've never had any problems with them", "We have got a very nice set of two

carers, three weeks on and three weeks off", "They do everything for her " and "I know the staff well". People described the staff as caring. Comments included, "Extremely kind and very helpful", "They're beautiful, wonderful and kind" and "The carers take my wife for walks, they've all been talented and helpful".

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

Rating at last inspection and update
The last rating for this service was inadequate (published 13 May 2020). Due to continued concerns about the service a targeted inspection was carried out in June 2020, ratings are not changed as a result of a targeted inspection, however urgent enforcement action was carried out as there were serious concerns about people's safety. At this inspection we found on-going concerns about the management of the service and continued multiple breaches of regulations. The service remains in special measures.

Why we inspected
We undertook this focused inspection to check whether previous breaches found in relation to Regulation 11, 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. We reviewed the key questions of safe and well-led only.

The overall rating for the service has not changed following the targeted inspection carried out in June 2020 and the comprehensive inspection carried out in March 2020 and remains inadequate.

Enforcement
The service has been in breach of regulations since 2018. We have identified continued breaches in relation to risk management, medicine management and record keeping. We took enforcement action to cancel the provider's registration. This means they will no longer be able to provide the regulated activity of personal care to people.

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded. There are no outstanding representations or appeals. Please see the end of this report for details of enforcement action taken.

Follow up
We will continue to monitor information we receive about the service. We have arranged regular meetings with the provider until they are removed from the register.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Universal Care - Beaconsfield

Detailed findings

Background to this inspection

The inspection
We carried out this focused 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 and one inspection manager. An Expert by Experience made telephone calls to people and their relatives. 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 and specialist housing.

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 we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 26 November 2020 and ended on 02 December 2020. We visited the office location on 26 and 27 November 2020.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. Whilst at the service we asked the registered manager to advise us on what improvements they had made since our last inspection and provided a further opportunity for them to share this with us after the site visit. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service and four relatives about their experience of the care provided. We spoke with six members of staff including the registered manager, quality and compliance manager, care co-ordinators and recruitment manager.

We reviewed a range of records. This included looking at 14 care records in total, safeguarding records, training records, complaints records and recruitment files for four staff. A variety of records relating to the management of the service, including policies and procedures were requested from the provider.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We reviewed record the provider sent us and received email feedback from staff, relatives, one person and one healthcare professional.

Inadequate

Is the service safe?

Our findings

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

At the last comprehensive inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our inspection in June 2018 the registered person had failed to assess the risks to the health and safety of service users receiving care or treatment. They failed to do all that was reasonably practicable to mitigate any such risks. This was a breach of Regulation12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At our inspection in August 2019 the provider had continued to put people at risk of avoidable harm. At the inspection in March and June 2020 we found continued breaches of regulation 12. The provider had routinely told us in action plans and other communication they would make changes to become compliant with this regulation.

At this inspection we found continued breaches of Regulation 12.

- People were not routinely and effectively protected from potential avoidable harm. We found the provider had not ensured they had done all that was reasonably practicable to mitigate risks. Risk assessments had not always been completed when required.
- We found people who had a diagnosis of diabetes did not routinely have a risk assessment in place. We discussed this with the registered manager who told us they, "Did not carry out a specific risk assessment in relation to the management of diabetes" but said that "All the required information should be in people's care records." We check what guidance was available for staff. The provider's policy stated, "Based on the information provided... the appropriate risk assessments will be completed to mitigate any risks identified and the client's consent to care will be obtained." We found this was not always the case. At least three people's records we looked at were diagnosed with diabetes and no risk assessment or additional guidance was available to staff.
- One person was diagnosed with a form of diabetes that meant it was difficult to control their blood sugar levels. We looked at the daily records completed by care workers for this person and found that Diabetic Nurse guidance was not always being followed. For example, the guidance stated that if the person's blood sugar levels dropped below a certain level care workers were to give 100mls of a sugary drink and continue to check their blood sugar levels to ensure they did not have a hypoglycaemic attack and require urgent medical assistance. We saw five occasions in the records between July and September 2020 where the person's blood sugar levels had dropped, and the guidance had not been followed. The guidance was not included in the person's care plan despite this guidance being in place from October 2019. A care co-ordinator had gone to review the person's care plan in October 2020 and some concerns had been identified about the management of this person's diabetes, however, at the time of the inspection, this had still not been addressed and the care plan and risk assessments had not been updated. This posed a serious risk to the person's safety.

● We previously reported on the lack or omission of effective risk assessments for people's medical conditions and prescribed medicines which had the potential to cause harm. At this inspection we looked at 13 risk assessments for medicines which had the potential to case harm had been written. We looked at minutes of a team meeting held on 2 October 2020, they referred to the quality and compliance manager writing risk assessments for people prescribed anticoagulant medicines. We reviewed the risk assessments written. They were all completed in November 2020 and failed to contain accurate or sufficient information. For instance, risk assessments routinely referred to "Carers MUST call paramedics immediately [Name of person] has a bad fall likely to cause internal bleeding, a nosebleed, cut or wound." No guidance was available for staff on what a "bad fall" was.
● Risks associated with people's dietary needs were not routinely and consistently assessed or followed. One person had an assessment that stated, "[Name of person] IS ON A SOFT FOOD DIET AND HAS THICKENER IN HIS DRINKS". However, a review of the person's daily notes found no reference to drinks being thickened and found the person routinely ate pizza. We discussed this with a care co-ordinator who advised the person chose not to have thickener in drinks and chose to eat pizza, despite the risks to their health. They confirmed with us they would seek updated advice from the health professional involved. One relative told us their family member was put at risk of choking as staff failed to observe the guidance on thickening fluids. The relative told us they had reminded staff about this.
● People who were diagnosed with diabetes had no information in their nutritional risk assessments to advise staff on what foods they should avoid eating or signs and symptoms of hypo and hyperglycaemic attacks to look out for so that staff could take appropriate action.
●Risks associated with the condition of people's skin were not always responded to in a timely manner. One person had been cared for in bed since the 7 September 2020, although this had been reported to the office and an Occupational Therapy referral made for the person. Their care plan and risk assessments had not yet been updated and there was no risk assessment in place to ensure that action was taken to prevent pressure ulcers. The records showed that this person had recently developed a pressure ulcer. This harm may have been avoided if appropriate action had been taken sooner to address this risk.

We found the provider had not addressed our previous concerns about the management of risk and systems were not in place to ensure people were protected from potential risks. This was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our inspection in June 2018 the registered person had failed to ensure people were supported with their medicines in a safe way. This was a breach of Regulation12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At our inspection in August 2019 the provider had continued to fully ensure people were supported safely with their medicines. This was a continued breach of Regulation 12. The provider had routinely told us in action plans and other communication they would make changes to become compliant with this regulation.

At this inspection we found continued and repeated breaches of regulation 12. People continued to be put at risk as a result of poor medicine management.

● People were put at risk due to unsafe medicine practices. One person had a diagnosis of diabetes, which required them to have daily insulin administered. The person told us the care staff supported them with this. The MARs for this person stated that they should receive insulin twice a day, once in the morning and once early evening. However, the daily records showed that additional insulin was given regularly by staff, but this

was not recorded on the MAR and this was not recorded in their care plan. The Diabetic Nurse guidance seen in the provider's records also did not refer to this. Therefore, care staff had no authority to administer additional insulin. A care co-ordinator had visited the person in October 2020 and had identified additional insulin was being administered, by care staff however, they had not referred this concern to any external healthcare professional.

● People were not always supported by staff to have their prescribed medicines at the right times and or as directed by the prescriber. One person's medicine record (MAR) stated that 5mg Prednisolone to be administered at 6pm, however observation sheets completed on the same day stated 'Prednisolone tablets x 8 given' which would not amount to 5mg. The same comment was recorded on 3 July 2020. Another person was prescribed Ferrous Sulphate to be given once a day. This medicine had not been signed for between 4-9 November 2020 and 17-23 November 2020 and there was no explanation for this. This medicine was also not listed on the office completed "Medication record". This meant the provider had not ensured staff followed their own medicine policy and care co-ordinators were unaware staff were supporting the person with the medicine.

● People were potentially placed at risk of harm due to incomplete medicine administration records (MAR). We found staff did not routinely follow the provider's policy and "Make a note on the client's Medication Chart (which is
kept in the client's Care Book) of all medication they have administered. The record must include the date, time, name of the medication (including creams, ointments and patches) and dosage given." We found daily records referred to medicine being administered but not recorded on the 'Medication Chart'. In one person's file we found three references to medicine being given in September 2020 and not recorded on the 'Medication Chart'.

● One person was assessed as not requiring any support with administration of their prescribed medicine. However, we read in their daily notes, staff had either prompted or assisted the person with their medicines on nine occasions in October 2020 and had administered analgesic cream on two occasions in November 2020 and barrier cream on a further two occasions in November 2020. We checked other records held about the person. No medicine chart had been completed. We discussed this with a care co-ordinator who had not realised the staff were supporting the person with medicines.

● We found records written by the office staff to advise care staff on what medicine should be administered did not routinely follow the detail on the prescribing label. One person was prescribed Diazepam. The prescribing label stated, "One to be taken for severe panic attack", the medicine record completed by office staff stated "2mg x1 to be taken at lunchtime if anxious". No additional guidance was available for staff on how the person's anxiety presented, or what actions they needed to take prior to administration of the sedative medicine. We also found it had been administered in the evening rather than at lunchtime.

At this inspection not enough improvement had been made. We found systems were either not in place or robust enough to ensure the proper and safe management of medicines. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they had confidence in the staff to support them with their medicines. Comments included "Extremely kind and very helpful".

Learning lessons when things go wrong

At our inspection in August 2019 the provider had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. At our last comprehensive inspection in March 2020 we found the provider failed to evaluate and improve their practice in respect of

the monitoring they had completed to drive forward improvements. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had routinely told us in action plans and other communication they would make changes to become compliant with this regulation.

At this inspection we found not enough improvement had been made. The provider had not ensured lessons were learnt when care was not delivered as planned or when accidents or near misses occurred. This was because systems where either not in place or ineffective to improve the quality of safety of services provided. At this inspection not enough improvement had been made and the provider was still in breach of Regulation 17.

● We found ongoing concerns about the recording of accidents and near misses. The registered manager told us "An appreciable improvement has been made not just in the health and safety policies but in actioning and learning from incidents." However, we found evidence of accident and near misses which had not been reported to the office.
● One person slipped from their bed on 2 September 2020, another person slipped in the shower when the staff were supporting them on 2 October 2020. We read in another person's daily care notes "caught her before she fully went on the floor". No accident/incident forms were completed, which meant opportunities to investigate and prevent a re-occurrence were missed.
● We found the provider failed to ensure staff followed the "Governance Policy" which the registered manager provided us with on 26 November 2020, which stated "The organisation will ensure that it has robust and transparent processes in place to ensure that incidents, mistakes and errors, including near misses, are identified, logged and investigated with appropriate learning and changes made which will inform the organisation's quality assurance processes".

We found systems were either not in place or effective to ensure learning from events was embedded into the service. The registered manager did ensure effective systems were followed to ensure staff took appropriate action when an accident did occur. This placed people at continued risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they knew what to do in an emergency. Comments included "I would ring for help then talk the emergency help through the incident and take any advice they would give me, get the client comfort depending on the situation, then let my manager know what's going on" and "I would report seizure, falls and any accident, I would call the emergency service to check the individual over write it down in the care plan the time and date that the accident happened, and when it started and finished and will informed the manager."

Preventing and controlling infection
● We found the service was not routinely and robustly following government guidance in relation to the spread of coronavirus. Senior members of staff did not routinely wear personal protective equipment (PPE) when in the office. The compliance and quality manager were seen on more than occasion not to be wearing any PPE. The registered manager was observed on two occasions not to be following government guidance and they wore their face mask around their neck with their nose and mouth exposed.
● We discussed with the quality and compliance manager our concerns about office staff not routinely observing social distancing and not wearing PPE. They told us they were "in a bubble" and did not have to observe this. However, office staff were visiting people in their own homes. This placed people at risk and demonstrated a lack of understanding by a senior member of staff.

● People told us staff did observe PPE guidance, one person told us "All my carers wash their hands as soon as they arrive and put on masks, gloves and aprons before they come near me. On leaving, they say goodbye, throw away their PPE and wash their hands. They all wear their blue, Universal Care overalls." However, one relative commented that staff kept "Pulling down their masks" when talking to her grandparents.

The provider failed to ensure senior staff followed government guidance in relation to wearing of PPE in the office. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they had access to enough PPE, and we observed staff visiting the service to collect more supplies.

Staffing and recruitment

At our inspection in June 2018 the registered person had failed to establish and maintain an effective staff recruitment procedure. The registered person had failed to ensure applicants were of good character and that information specified in Schedule 3 was available for each staff member. This was a breach of Regulation 19 (Fit and proper persons employed) and Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the last inspection in August 2019 we found not enough improvement had been made and the registered person was still in breach of Regulation 19 and Schedule 3. At our last comprehensive inspection in March 2020 we found some improvement had been made. The provider had routinely told us in action plans and other communication they would make changes to become compliant with this regulation.

However, at this inspection we found some concerns with the provider's compliance with regulation 19.

● Recruitment checks were not always fully completed to ensure that staff were suitable to work with people using the service. Checks of staff recruitment records showed that a criminal records check had not been completed for a member of staff who was due to commence work the following week. We asked the provider about this and he confirmed that this check had not yet been applied for and gave no explanation for this. Only one reference had been received for this staff member and it was noted that they were currently working for another care agency. A reference had not been requested from this agency and there was no evidence that this had been explored with the staff member.
● In another staff member's recruitment records we found that there was no proof of identification as required and only one reference.

The provider had failed to ensure people were supported by staff with the right character and attributes to provide safe care. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At our inspection in June 2018 the provider had failed to ensure staff received appropriate training and supervision as was necessary to enable them to carry out the duties they were employed to perform. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the inspection in August 2019 we found not enough improvement had been made in relation to staff training and the provider was still in breach of regulation 18. At the inspection in March and June 2020 we found some improvements had been made, but the provider remained in breach of regulation 18. This was because risks to people were not always mitigated because of continued gaps in training.

At this inspection we found some improvements had been made. We however did not look at all the training requirements or staff support records. Therefore, we cannot be assured the service was compliant with regulation 18.

● We found improvements had been made with ensuring staff have the right skills to meet people's needs. For instance, people who had specific needs were supported by staff who had the right training. For Instance, care staff who supported people who required nutrition and hydration via a percutaneous endoscopic gastrostomy (PEG) had received training on how to support them safely.
● People were supported by the right amount of staff. People who had the need for two staff to support with moving position had this routinely provided.
● People and their relatives told us they were content with the level of support provided. Comments included "I've got a lot of confidence in the carers, they do everything for me", "We have got a very nice set of two carers, three weeks on and three weeks off", "I know the staff well".
People told us staff were kind and caring towards them. Comments included "All the carers are very good and kind", "I am very happy with them" and "The carers provided by Universal are 1st class".

Systems and processes to safeguard people from the risk of abuse
● People were supported by staff who had safeguarding training. Since the last inspection the provider had updated their safeguarding policy following our advice.
● People told us they felt safe with the staff. Comments included "I feel very safe with the carers and when she was unwell, they took her to see her GP", "I rate them safe" and "Was safe with the carer."
● Since the last inspection the provider had reported allegations of abuse to the local authority and had worked alongside them to help investigate concerns raised. However, records regarding the provider's own investigations could have been improved. We have provided feedback to the registered manager to ensure this occurs in the future.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our inspection in August 2019 the provider had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). The provider failed to evaluate and improve their practice in respect of the monitoring they had completed to drive forward improvements. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the inspections in March and June 2020 we found not enough improvement had been made and the provider was still in breach of regulation 17. The provider had routinely told us in action plans and other communication they would make changes to become compliant with this regulation.

At this inspection we found a continued breach of regulation 17. We found the provider failed to assess, monitor and mitigate risks posed to people. We also found the provider did not maintain accurate and complete records of decisions made about people's care.

● People were not routinely and consistently protected from risks and avoidable harm. We found the provider did not update people's care plans in a timely manner, following changes to their circumstances. This was because the provider did not have effective systems in place to monitor whether people's care plans were updated when changes occurred in their care needs. To ensure prompt action could be taken so staff had up to date information about how to support them.
● There was unacceptable delays in updating care plans when people's needs changed. One person had needed to be cared for in bed since the 7 September 2020. The care plan did not reflect the person's current needs. We discussed this with a care co-ordinator who advised they were in the process of updating the care plan. Another person had received a change in their medicines. The staff informed the care co-ordinator of this, however, the care plan and medicine record written the same day did not contain the change in medicine.
● People were not referred to external healthcare professionals in a timely manner. One person's needs had changed on 7 September 2020, a referral to an occupational therapist was not made until 25 September 2020. This meant the person was left without appropriate equipment.
● Care records written by the quality and compliance manager were inaccurate. We discussed three records with the quality and compliance manager who had signed risk assessments and care plans. One record

stated the assessment had been carried out at the person's home at a certain time. However, the person was in hospital at the time. We discussed the person's records with the quality and compliance manager who had signed the risk assessment and care plans. They told us they had telephoned the husband to seek guidance on the assessment. We discussed another two cases where people were in hospital at the time and date of the assessment, with the same member of staff and they informed us they had relied on previous information to complete the care records. We received no evidence the person had been consulted or visited to complete the assessment.

● Records were not routinely maintained to be accurate. For instance, changes were made to care plans and the date of the assessment was not changed. We found care plan records had other people's names mentioned in them. For instance, in one male care plan there was reference to a lady's name. Medicine records were not routinely kept accurate. We found gaps in records which demonstrated what medicines had been administered.

● The registered person did not routinely ensure staff followed the provider's policies. We found the risk assessment policy which stated, "Universal Care has a responsibility to do a risk assessment and this cannot be delegated", did not routinely get followed. Other processes which had been introduced, for example, care file audits and medicine audits did not drive improvement. For instance, care file audits did not pick up the issues we found about the risks to people.

We found people were placed at continued risk of harm as effective governance arrangements were not in place. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the inspection in 2019 we found the provider failed to inform us of all reportable events. This was a breach of regulation 18 (Notification of Other Incidents) of the Care Quality Commission (Registration) Regulations 2009. At the last inspection in March 2020 we found some improvements had been made. However, not all reportable events were notified to us. We found this was a continued breach of regulation 18 (Notifications of other incidents) of the Care Quality Commission (Registration) Regulations 2009. At the inspection in March and June 2020 we found a continued breach of regulation 18.

At this inspection we found improvements had been made at the service and was no longer in breach of regulation 18.

● The management committee had a policy to ensure all reportable events were notified to us. We checked records held at the service and records we had received. We found no gaps in the reporting of important events to us.

Continuous learning and improving care

At our inspection in August 2019 the provider had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. At the inspections in March and June 2020 we found the provider failed to evaluate and improve their practice in respect of the monitoring they had completed to drive forward improvements in particular for learning from incident and accidents. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had routinely told us in action plans and other communication they would make changes to become compliant with this regulation.

At this inspection we found on-going concerns and breaches of regulation 17.

● We found all accident, near misses and incidents were not recorded, or reported to the registered

manager.
● The registered manager had met with us and the Local Authority regularly to review an action plan to drive improvements. In the last meeting held and on the day of the inspection they advised advised us they had completed all but three actions detailed. They had worked with their quality and compliance manager. The registered manager told us they were confident sufficient improvement had been made to comply with the regulations. However, we found this not to be the case. We found on-going and continued breaches of the regulations. The systems stated in the action plan had not been imbedded or fully adopted to drive improvement.
● The registered manager told us "I can assure you that I am continuously learning as a result of information which I receive from the United Kingdom Homecare Association (UKHCA), from our Quality and Compliance Manager and the Care Consultant. My team and myself have also learnt much from the comments which you have made to me in relation to returning and new clients which we have referred to you." However, we found this was not the case.

We found people were placed at continued risk of harm as effective governance arrangements were not in place. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At the last comprehensive inspection in March 2020 we recommended the provider sought guidance from a reputable source to ensure the duty of candour requirements were fully understood by all staff.

At this inspection we found some improvements had been made.

● Providers are required to comply with the duty of candour (DOC) statutory requirement. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to registered persons when they are carrying on a regulated activity.
● The registered manager had written an apology to a relative following a complaint about the conduct of an office staff member. The registered manager also discussed other cases where they had taken disciplinary action following incidents when staff had not carried out safe practices.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People told us they were not routinely involved in decisions about their care. When we asked people about their care plan, they told us the care plan "Was put together by the office".
● Relatives told us they were not routinely involved in writing care plans or asked for feedback on the service.
● We received mixed feedback about the office and communication. Positive comments included, "My care co-ordinator was outstanding" and communication was "Prompt". Other comments included "Staff were kind and caring ... only last week a lady from Universal's office visited"(to go over her care plan) and one relative told us they were "Aware of a care plan." People and their relatives told us they had some concerns

with communication with the office. We asked people about the level of confidence they had in the service. Comments included "Definitely in the carers, not so much in the office. Since the CQC have got involved things are more regulated" and "The administration could be sharpened up". Another relative told us "The owner of Universal is the only problem, not listening and sending the wrong carers".

We recommend the service seeks support from a reputable source about involving people in decisions about their care.

● We found people's care records contained information about how they wished to be communicated with. This demonstrated understanding of the Accessible Information Standard. The Accessible Information Standard was introduced to make sure that people with a disability or sensory loss are given information in a way they can understand.
● The service arranged for an independent satisfaction questionnaire to be sent to people this year. The results were summarised in a report dated August 2020. The results found 95 percent of completed questionnaires showed people were satisfied with the service provided by Universal Care-Beaconsfield and 93 percent of people supported would recommend the service.
● Staff told us they had a positive relationship and felt supported by their line manager. Comments about the care co-ordinators included "Very supportive and accessible", "I have found them to be good, fair and on the ball" and "It is a pleasure to speak with her and she has always been extremely helpful."

Working in partnership with others

● The service worked with local GP's, district nurses and other healthcare professionals. We found some delays in referrals being made. People told us they were supported to access healthcare. One relative told us "They worked closely with the local social services to ensure my dad (and more recently my mum) received the appropriate equipment and aids to make their lives as easy as possible. The registered manager told us "I have personally had either telephone or email communications with Thames Hospice, Rennie Grove Hospice at Home, the local Parkinson's group, UKHCA and other local domiciliary care agencies."
● A healthcare professional told us "I would not hesitate to recommend Universal Care to friends and family."

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure all risks posed to people were mitigated. We found people were put at risk from unsafe medicine practice.

The enforcement action we took:

We have proceeded to cancel the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider has been in breach of regulation since 2018. Systems were not effective in driving improvement. we found records were not routinely accurate or updated when changes occurred in people's needs.

The enforcement action we took:

We have proceeded to cancel the providers registration.