Unicaredevon Limited

Unicare Devon

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

Summary of findings

Overall summary

About the service: Unicare Devon is a domiciliary care agency that was providing personal care to 77 people at the time of the inspection. It supports people with different needs and backgrounds including people with mobility, learning, or sensory support needs, and older people with dementia. Unicare Devon also provides enabling and support services to people in the Newton Abbott area these activities are not regulated and so we did not inspect this side of the service.

People's experience of using this service:

Risks associated with people's care needs were not always appropriately assessed and risks that staff may have faced were not documented.

The service did not have up to date assessments of care needs and information for staff on how to provide support to people using the service.

Quality assurance systems to assess, monitor and improve the quality and safety of the service were not in place.

Some care files lacked personalised information on how people wanted to have their care delivered. Staff knew people well and reflected what people told us about themselves.

Information was available to people in accessible formats if they needed it. The service treated people with dignity and respect and staff had training in equality and diversity.

People told us that occasionally staff were late but they stayed for the duration of the visit and met their needs.

The service had a caring, person centred ethos, there were several examples where staff had gone over and above what had been expected of them. People and relatives told us staff were kind and caring.

People were offered choice, in how they had their personal care delivered, what food staff prepared for them and what clothes they wore.

People were supported by staff who had been through a robust recruitment process that checked they were safe to work with people who may be vulnerable.

Staff and the registered manager knew how to spot signs of abuse and how to report them. Staff had attended safeguarding adults training.

Staff felt supported by the registered manager and listened to when they gave feedback.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practise. People told us staff asked them for consent before supporting with care tasks.

We found the service was in breach of two regulations relating to safe care and treatment and good governance.

Further information is in the detailed findings below.
Rating at last inspection: Unicare Devon was rated good at its last inspection on 14 July 2016, the report was published on 3 August 2016.

Why we inspected: This was a scheduled inspection based on the previous rating.

Follow up: We will ask the provider to send a report of actions to us within a specific timeframe relating to the breaches of regulation we have identified in this report. We will continue to monitor the intelligence we receive about the service, and invite the provider and registered manager to meet with us regarding how they plan to make improvements to the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our Well-Led findings below.

Unicare Devon

Detailed findings

Background to this inspection

The 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.

Inspection team: The inspection team consisted of one adult social care inspector, one adult social care assistant inspector and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type: This service is a domiciliary care agency. It provides personal care to people living in their own homes in the community.

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 visit because we wanted to ensure there would be someone in the office.

What we did:
Before the inspection we gathered information we had regarding the service. We reviewed notifications the service sent to us. A notification is a report the provider sends to us every time there is a significant event or incident.

The registered manager sent us a PIR or provider information return. This is a document that contains information on how the service is developing and any planned improvements.

During the inspection we spoke with 12 people using the service and five relatives. We spoke with three professionals, five care staff, two directors, one office based staff member, and the registered manager.

We looked at eight people's care records, and saw how the planning, rota and recording system was used.

We also looked at five staff training and recruitment files, audits, complaints, incidents, policies, and visited one person at home.

After the inspection we asked the registered manager to send us some further information which they did.

Requires Improvement

Is the service safe?

Our findings

Safe – we looked at whether people were protected from abuse and avoidable harm.

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management, learning lessons when things go wrong:
• Risk assessments were not in place for people identified at risk of harm. For example, one person with diabetes had no risk assessment in place to inform staff how best to support them if they became unwell. For people at an identified risk of pressure ulcers there was no skin integrity risk assessment. For another person who was at an identified risk of infection due to their support needs around catheterisation there was no risk assessment in place. For two people who required positive behaviour support assessments and plans these were not in place. There were no risk management plans in place to inform staff how to best support some people and mitigate the risks they faced. This placed them at the risk of receiving unsafe care and treatment and avoidable harm.
• The safety of staff was not assessed for every home visit they might attend. There were no environmental or lone working risk assessments for some properties that staff visited. The registered manager and staff told us there was an ongoing risk of staff being verbally or sexually abused at one person's home. There was no risk assessment in place for this. We asked staff what risk measures were in place and they told us what they did to keep safe. However, there was no record of the risks this person posed to themselves or staff, or what staff should do to protect themselves if they were unfamiliar with the person or their needs changed.
• We asked the registered manager and a director why risk assessments were not in place for identified risks to people and staff. The registered manager said, "Because of the new electronic system some of them have not been transferred across and some have not been written, they aren't on the system, there are holes." The director we spoke with said, "We thought they were done, we won't let it happen again."
• The service was unable to provide us with examples of where they had learned lessons when things went wrong. We asked the registered manager if they had any records where they had reviewed incidents. There was no overview or analysis of incidents or a log that confirmed when incidents had occurred.

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

Safeguarding systems and processes:
• People told us they felt safe receiving care and support from Unicare Devon.
• The service had robust recruitment processes to check if potential staff were suitable to work with vulnerable people. New staff were interviewed and recruitment files showed appropriate references and employment history. Criminal record checks had been completed before new staff started working with people.
• Staff and the registered manager could identify the signs of abuse. When we talked with them, they understood how and where to report any safeguarding concerns. Staff received training in how to safeguard people.

Staffing levels:
• People who needed the support of two staff to help them to move or have personal care said there were always two staff available and they arrived together.
• The service had a procedure whereby a care visit was identified as 'late' if the staff member arrived 30 minutes after the allotted time. This was noted on the front of care files in people's homes and the registered manager told us people were told of this during their initial assessment. When we spoke with people they weren't always aware of this and felt that staff were sometimes late and the service did not always notify them of it.
• Three people we spoke with said they felt the staffing was unpredictable and left them feeling stressed and confused. One person said, "I get stressed, I don't know who is coming, then I get someone completely different." Another person said "I think they are more focused on care. I can't schedule a week – it's stressful and there's no predictability. They don't communicate if they make a change in the schedule." We asked the registered manager how they communicate changes in staffing to people, they said it was sometimes hard keeping up with staff changes and the office was very busy and they did their best to call people to keep them apprised of changes. Despite this feedback, we found most people we spoke with said staff did turn up to planned care visits and stayed the duration they were supposed to.

Using medicines safely:
• People told us they were happy with how they were supported to take their medicines.
• Staff had attended training in how to safely administer medicines and their competency was tested on spot checks by senior members of staff.
• Medicines administration was recorded by staff on electronic medicine administration records (EMAR). We asked the registered manager how they knew if the medicines on the electronic system were up to date as they were entered manually. The registered manager said staff fed back to them any changes in medicines. One person's EMAR we looked at had some medicines that the person had told us they no longer took. We asked the service to follow this up and check what medicines the person required support to take and update their records accordingly.
• One person's allergy information was recorded inconsistently across care documents. The allergy to a specific medicine was noted on their care plan but not reflected in their profile that staff would get an overview from. This placed the person at risk of potentially receiving care or treatment that may cause them harm due to records that were inconsistent.

Preventing and controlling infection:
• Staff had infection control training as part of their induction. They said, "We always have enough gloves and aprons."
• People told us they saw staff using gloves and washing their hands.

Requires Improvement

Is the service effective?

Our findings

Effective – this explains whether people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

The effectiveness of people's care, treatment and support was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
● People's needs were not always fully assessed. There were assessments missing from people's files for needs that were noted but not explored. We asked the registered manager why this was. They told us, "We used to have an assessment worker but they left a while ago and we are struggling without this extra member of staff. Assessments are something we need to catch up on." The service had put some interim measures in place and were supporting senior members of staff to complete assessments.
• The service used a traffic light system to review people's needs. However, this system was not evident from the care files we reviewed. One person's care file had not been reviewed since November 2017. We asked the registered manager if there were any newer assessments of their needs either in paper or electronic formats and they said there were not. They further confirmed that the person's needs had changed since they were last reviewed.

Staff skills, knowledge and experience:
• The service had no clear system to demonstrate what training had been completed by staff. The director confirmed this was due to changes from one system to another. They told us, "Moving from the old system to the new has been problematic."
• Staff had received training in moving and handling so they could support people with mobility needs.
● When we spoke with staff they could demonstrate knowledge in safeguarding adults, person centred care, consent and medicines.
• People and relatives said staff seemed skilled and knowledgeable. One person said, "They are very competent and well trained. I know they are always trained before they come out."
• Staff told us they felt supported and had received supervision. Records were not always in place for all supervisions. Appraisals had been completed for senior staff and booked in for all other staff.

Supporting people to eat and drink enough with choice in a balanced diet, supporting people to live healthier lives, and access healthcare:
● People and relatives told us they were happy with how staff supported them to eat and drink. One relative said "When they help with making food it gives me a break." Another said, "They always make me teas and refill my water bottles before they go."
• We looked at records for people with a PEG (percutaneous endoscopic gastrostomy) where a tube is passed through the abdominal wall and into the stomach so that food can be put through it. Staff had received training in how to support people with a PEG.
•Where one person had set themselves a goal to be a healthier weight, staff had supported them to achieve their goal.
• Records confirmed referrals were made and showed regular contact with staff when healthcare

professionals were involved. During the inspection we observed managers and office staff speaking with healthcare professionals, and saw a focus on supporting people to improve their health through access to services.

Ensuring consent to care and treatment in line with law and guidance:
● The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. We found the service was acting within the principles of the MCA and appropriate recording of whether people had capacity to make decisions and power of attorney details were evidenced.
• Care plans had signed consent documents in place.
• Staff and the registered manager had a good knowledge of the MCA framework.
• People told us staff always asked for consent and explained what they were doing when supporting them.

Good

Is the service caring?

Our findings

Caring – this means that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported:
● People were supported by staff who knew people's needs well.
• People said, "They are very caring, I don't know what I would do without them" and "They are careful, kind and gentle." One person told us the staff washed up so their husband didn't have to, despite not being paid to do it.
• The service bought gifts for people who were alone at Christmas. The registered manager visited one person at Christmas with their family so they would not feel alone.
• Staff spoke of people with fondness and told us they loved their jobs. One staff member said, "The people I visit are like my family."
• We asked the provider for an example of where the service had gone beyond people's expectations. They said where there had been heavy snow in 2018 they ensured not one visit was missed and staff walked to visits and managers arranged transportation so people still received care.

Supporting people to express their views and be involved in making decisions about their care:
● People told us they were offered choice in what they ate how they received their personal care and how it was provided.
• The registered manager said that people were matched to care workers based on a combination of availability, skills and interests. But sometimes they did not always get along so the care worker was changed. Where possible the service tried to provide the requested gender of the care worker.
• Nine people that we spoke with said they had been visited recently by staff to discuss their needs and were asked if they wanted anything to be changed. One person said they had a review visit six months ago and two people said they did not know or did not remember. One person we spoke with said, "We talk about my needs every time they visit, and that's more than once a day. I'm happy they know what I want."

Respecting and promoting people's privacy, dignity and independence:
● People told us they had been asked by the service what they preferred to be called and that staff respected this and addressed them in the manner they had asked for.
• Staff told us they respected people's privacy during personal care by drawing curtains, closing doors, leaving the room once a person had been supported on to the commode and covering people when receiving personal care. People and relatives told us staff respected people when delivering personal care. Staff told us they had received training in dignity and respect.
• One person we spoke with said, "I am fiercely independent and they know that, they get it right so my pride isn't hurt." Another person said, "They get things for me if I can't reach or I'm feeling unwell." Care plans confirmed guidelines to ensure people were encouraged for example, to remain mobile through walking and going out into the local community.

Requires Improvement

Is the service responsive?

Our findings

Responsive – we looked at whether the service met people's needs.

People's needs were not always assessed. Regulations may not have been met.

Personalised care:
● Care files were lacking information about people's life histories including their past occupations and important events in their lives. There was no information on future aspirations and goals for staff to help people work towards.
•The electronic system focussed on a list of daily tasks the person required support with rather than how they would like to be supported. This meant the structure of the system was task focussed and contained little detail of preferences or how people liked to be supported.
•Despite records containing little detail of the person's preferences staff had a good knowledge of how people liked to receive their care and support.
• The service identified that some people receiving personal care were lonely or isolated. They had converted the lower ground floor of the office building so people could have lunch, or a shower, and socialise in a safe, homely space should they be feeling lonely or isolated.
•The service took people's sensory needs into consideration and how this might affect how they took in information. It had braille, easy read and recorded versions of its 'service user guide' for those that might need it.

Improving care quality in response to complaints or concerns:
● People were provided with details of how to complain and the relevant timescales their complaints would be dealt with.
• People and relatives told us they knew how to complain and felt comfortable talking to staff on care visits or contacting the office to speak with a team leader or manager.
• Electronic records showed that complaints were responded to within the service timeline and people were given a response and this was documented.

End of life care and support:
● For one person receiving end of life care it was not documented that they were nearing the end of their life to ensure staff had full information. After the inspection we were sent evidence that staff were kept up to date via email and messages from the service's office with people needs, but care plans did not reflect these updates.
• Some staff had attended additional training on end of life care and this was also covered in the induction for new staff.
• There were details in some people's care records of what their end of life wishes were, for other people it was not appropriate to have those conversations.
• We saw an example where a person had been supported to have their end of life wishes met by responsive and flexible staff, despite several challenges being posed to staff in meeting these.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – we looked to see if the service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:
• Quality assurance systems were not in place to assess, monitor or improve the quality and safety of the care provided. The registered manager told us they did not have any records to evidence care plan, risk assessments, MAR charts, or visit times were being monitored for any shortfalls. We asked the registered manager how they assessed and monitored the service day to day. They told us they responded to issues as they arose and were currently "firefighting" issues as they came in, rather than working to prevent them.
• Some people told us they were not always informed if staff were late. There was not an adequate system in place for the service to review any patterns or trends in visit times or lateness and act accordingly to improve people's experience.
• We found several risks were not assessed relating to people and staff. Staff could tell us and had evidenced in care notes that they were able to dynamically risk assess and mitigate some risk factors by responding appropriately to situations that arose. However, there was no formal risk assessment in place to tell staff how to consistently mitigate risks for people and staff. This related to abusive behaviours, environmental risks, lone working, and associated health risks for people with catheters, diabetes, and alcohol dependency, among other identified needs.
• The service failed to maintain an accurate, complete and contemporaneous record in respect of each person and their current needs.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The registered manager was fulfilling more than one role in the office, this impacted on their ability to perform their role effectively.
• Staff had a good understanding of their roles and what they should be doing to provide high quality care.
• By the end of the second day of inspection we were presented with a newly written quality assurance process the provider told us covered the assessment, monitoring and improvement of the quality and safety of the service when implemented. This showed the provider and registered manager were taking our feedback seriously, had acted quickly and wanted to implement improvements in a timely manner.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on duty of candour responsibility:
•The service informed relatives of any concerns if an accident had happened, and fulfilled their duty of candour.

• The directors and registered manager cared about providing a high-quality service to people, they were responsive and open during the inspection and assured us their focus would be put back on improving the service.

Engaging and involving people using the service, the public and staff:
• People were involved in the planning and review of their care needs where recent assessments had taken place.
•The provider had identified a need for local people and people using the service to reduce isolation and created a service with thoughtful facilities such as a wheelchair height movable kitchen, commissioned in the building to meet that need.
• Staff told us they felt listened to, were supported by the registered manager, and had an input into the service.
• People said they thought the management team was helpful and kind. One person told us, "I don't know what I would do without her [the registered manager]."

Working in partnership with others:
• The service worked in partnership with key health and social care professionals and evidenced communications with health services.
• The provider was linked in with other organisations to share best practise.

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 service failed to provide care and treatment in a safe way to service users. It failed to assess the risks to the health and safety of service users and to do all that is reasonably practicable to mitigate any such risks. Regulation 12 (1) (2) (a) (b)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service failed to establish and operate effectively a system to assess, monitor and improve the quality and safety of services. It failed to assess, monitor and mitigate risks and did not securely store an accurate, complete and contemporaneous record of needs and support the service user received. Regulation 17 (1) (2) (a) (b) (c)