Universal Care Services (UK) Limited

Universal Care Services Leicester

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an announced comprehensive inspection of this service on 23 February 2017. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk.

Universal Care Services – Leicester provides personal care to people living in their own homes. On the day of the inspection the registered manager informed us that 41 people were receiving a personal care service from the agency.

This inspection took place on 13 September 2017. The inspection was announced as we needed to be sure that someone was available to carry out the inspection with us.

At our last inspection in 23 February 2017 the service was not meeting regulations with regard to having systems in place to ensure quality services. We followed up these issues and found some improvements had been made, though further improvements were needed to show that people did receive a quality service.

A registered manager was in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Risk assessments were not consistently in place to protect people from risks to their health and welfare.

Calls to provide care to some people were not always at the agreed and assessed times, which meant people's safety had not been comprehensively promoted to ensure they received care at the times they needed.

People and relatives we spoke with told us they thought the service ensured that people received safe personal care from staff.

Most people and relatives were satisfied with how the service was run, though there were concerns about missed care calls and calls not being on time. Not all staff felt they were supported in their work by the senior management of the service.

Notifications of concern had been reported to us, as legally required, to enable us to consider whether we

needed to carry out an early inspection of the service. Management had not comprehensively carried out audits in order to check that the service was meeting people's needs and to ensure people were provided with a quality service.

The service was still in breach of one of the regulations of the Health and Social Care Act 2008 and remains rated as Requires Improvement. You can see what action we told the provider to take at the back of the full version of the report

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People and their relatives thought that staff provided, in the main, safe care. People's health needs had been attended to. However, risk assessments and practice to protect people's health and welfare were not fully in place to protect people from assessed risks. People had not always received care at agreed times.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems had not been comprehensively audited in order to measure whether a quality service had been provided. Some staff told us that office management staff did not always provide good support to them. Most people and their relatives thought it was an organised and well led service. Legal notifications had been sent to us.

Universal Care Services Leicester

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook an announced focused inspection of Universal Care Services on 13 September 2017. This inspection was carried out to check that improvements to meet legal requirements planned by the provider after our 15 February 2017 inspection had been made. This is because the service was not meeting the legal requirements of Regulation 12, Safe Care and Regulation 17, Good Governance.

The inspection team consisted of one inspector.

We also reviewed the notifications we had been sent and the action plan from the provider to meet the breaches of regulations from the last inspection. Notifications are changes, events or incidents that providers must tell us about.

We contacted commissioners for health and social care, responsible for funding some of the people who used the service and asked them for their views about the agency. The local authority commissioning unit stated that there had been issues with regard to meeting the needs of people using the service, but once this had been brought to the attention of the service, the registered manager had worked to ensure that the service improved so that it could meet people's needs.

During the inspection we spoke with six people who used the service and six relatives. We also spoke with the registered manager, the regional manager, and four care workers.

We looked in detail at the care and support provided to four people who used the service, including their care records, and audits which checked whether people were provided with a quality service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 27 February 2017, there had been a breach of Regulation 12 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014, Safe Care. This was because risk assessments to keep people safe were not sufficiently detailed to support staff to deliver safe care. Some care practice had not protected people's health needs. Calls had not been delivered on time to safely promote people's health and welfare needs.

The provider submitted an action plan which covered relevant issues such as having comprehensive risk assessments in place, ensuring staff followed care plan instructions and staff completed calls in accordance with agreed times. During this inspection we found that issues had improved overall. However, there were still some unresolved issues about untimely calls and the provision of care for some people.

We spoke with people and relatives. They told us that staff had, in the main, provided safe personal care. One person told us, "They make sure I don't fall. They remind me to use my frame." Another person told us, "Yes, safety is no problem." Another person said, "Staff are good. No problems." A relative told us, "I couldn't ask for anything better. They are brilliant."

We checked incident and accident records. We found that staff had responded to people's needs. For example, when a person had fallen or had been feeling ill, staff had responded properly by ringing the ambulance or reporting these issues to relatives, who had then contacted health professionals. This practice safely promoted people's health needs.

Staff told us they were aware of how to check to ensure people's safety. For example, they checked that equipment was working properly and they were no obstacles that could trip people up. This awareness helped to keep people safe.

The assessment of a person stated that there was a fire risk. There was a risk assessment was in place to manage this risk. We asked a staff member how this was carried out and they were aware of the risk factors and how to deal with them. This meant that steps to prevent or reduce the fire risk to the person had been safely managed.

We saw that people's care and support had not always been planned and delivered in a way that ensured their safety and welfare. For example, a person had been assessed as having a risk of pressure sores. There was a risk assessment in place which directed staff to monitor the person. The revised assessment included important information such as the need to apply cream to manage at risk skin areas. There was also an updated support plan which stated that staff needed to reposition the person to maintain the person's skin integrity. As the previous support plan had not been dated, it was not clear at what point the person needed to start having creams supplied.

However, the "service location profile" on 23 May 2017 and daily records showed that the district nurse had been involved at the end of July 2017 with regard to the treatment of pressure areas on the person's skin.

This indicated there was a risk of other pressure sores developing. However, care records did not always show that cream had always been applied. Continence pads had been changed three times that day, but records did not indicate that cream had been applied on any of these occasions. We asked the relative of this person with regard to staff applying creams and they told us, to their knowledge, staff did apply creams. This appeared to indicate that the application of creams had been provided but records did not always record this. The registered manager said staff would be reminded to record when cream was applied to evidence that safe treatment had been supplied.

There was also a record of repositioning the person. This had been completed, as needed, four times a day on most days. On some days, repositioning was only recorded two times a day. This indicated that the person may not have been provided with care that met their needs. The registered manager acknowledged this and said that staff would be again reminded to complete records.

One person told us that they needed to have cream aupplied to keep their skin healthy. The person said this had been carried out by their "main carers [staff]" but not always by other staff. They said that staff had told them that they did not have time to do this. The registered manager followed this up and stated that the person or their relative had never indicated this before.

A risk assessment for another person stated that the person displayed behaviour that challenged the service. It stated that staff should seek support if this behaviour was displayed. However, the risk assessment did not include information such what methods were needed to manage the behaviour. The registered manager acknowledged this and said that the risk assessment would be updated to include this information.

A staff member told us that they had been informed by a colleague that a person had an infection. This had caused her surprise as she had been working with this person for a number of months and this condition was not in the care plan. The registered manager sent us a care plan dated May 2017 which stated the person had the infection. There was no risk assessment in place to manage this condition though the care plan did state that staff needed to use specific proper equipment, which would prevent infection spreading. This would manage the risk of staff contracting the infection and passing it on to other people using the service. The registered manager followed this up and later confirmed that the person no longer had this condition.

Most people and relatives we spoke with said that there had been proper timeliness of calls to deliver care. However, other people and relatives told us that staff could be very early or late for calls. One relative told us, "Being left in bed when staff turn up late is not good. They [family members] need help to go to the toilet and wash."

A friend of a person using the service said that there had been three or four missed calls in the past six months, where staff had not turned up. They also told us that they had noticed a staff member recording that they had been on time for a call when they had seen the staff member leave at another time. Therefore, they said the staff member had falsified the record. The registered manager followed up this issue and was taking action with regard to this issue.

People could not be assured that staff would arrive to provide their care at the agreed time We looked at care records and found that a number of call times were later than the agreed time. For one person, the tea-time call was an hour late. The call time was 4pm. On 17 August 2017 the call was carried out at 5pm, an hour late. On 21 August the 9.30pm call was carried out 9.03pm, 27 minutes early. On 26 August the tea-time call of 4pm was carried out at 6.15pm, over two hours late. For another person, the call time was 6.00am on

5 September 2017 but staff had arrived at 6.49am, 49 minutes late. Later that day the person received a call at 12.40 pm, when the agreed call time was 11.30am, 70 minutes late. The following day the lunchtime call was 61 minutes late and the evening call was 54 minutes late. The following day, 7 August 2017, the lunchtime call was 55 minutes late. On 29 August 2017, the lunchtime call was 41 minutes late. The following day, on 30 August the lunchtime call was 54 minutes late.

We checked the care records of another person. A number of call times were late. For example, on 15 August 2017 the call had been at 17.50pm, when agreed time was 17.00pm, 50 minutes late. This call was also 50 minutes late the following day. On 17 August 17 this call was 52 minutes late. This meant that some people were not always receiving care at the agreed assessed times. This did not safely meet their health and welfare needs. The August 2017 audit of care records had not recorded any issues with the timeliness of calls.

When we asked staff about getting to people on time, four staff said that sometimes there was no travelling time allowed by the office. One staff member said that for 19 calls they had to carry out in one day, only two calls had any travelling time. Another staff member said that of the six to nine calls they had, only two or three calls had any travelling time. This meant that they were late for calls on many occasions. They said they had raised it with the registered manager and office management staff as some people had complained about late calls. They were told that as there was an allowable 15 minute window to arrive to calls, this would meet this issue.

Staff told us that they were asked to do extra calls because there were not enough staff available. The registered manager told us staffing levels were sufficient to provide care to people. She would follow up concerns with staff and check whether travelling time had been included.

One person said that they had three main staff that provided care. The staff stayed the full time of the agreed call. However, other staff often would leave the call 10 to 15 minutes before the agreed time. They also said there had been one call where staff had not turned up. Another person said that staff turned up late for their afternoon call. The registered manager followed up these issues. She provided information which indicated that a person had cancelled calls due to hospital appointments. She also stated that the call times for the other person had been late and action was being taken with staff about this issue.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection, there was a breach of Regulation 17, Good Governance. The provider submitted an action plan which covered relevant issues such as having medication auditing systems in place to ensure the quality of the service.

At this inspection we found improvements had been made. For example,
incidents of alleged abuse had been reported to CQC as legally required. However, although an auditing system to check whether quality care had been provided was in place, this was not completely effective.

We saw quality assurance checks such as care records audits to check the quality of the care provided and that calls had been made within required times had been completed. However audits did not always identify issues such as whether there were late or early calls. Care records showed people's call times had been late. For example, when we looked at one person's care records for August 2017, calls had been late by 50 minutes or more. This meant that some people were not always receiving care at the agreed assessed times. This did not safely meet their assessed health and welfare needs. However, the August 2017 audit of care records had not recorded any issues with the timeliness of calls. This meant provider had not utilised their own internal call monitoring system effectively to ensure that people received the care that they needed at the right time.

We checked the electronic monitoring system that recorded when staff attended calls. For one record, we found a staff member had been over an hour late for some calls. This had not been identified by the audit system.

We saw evidence in the service's September 2017 customer satisfaction survey a minority of people said that staff were not always on time for calls. However, no specific action was recorded to deal with this issue to ensure people received a service meeting their needs.

With regard to people's risk assessments and the care provided to reduce risk, there had been no audit in place to identify whether proper risk assessments were in place for relevant issues. For example, to reduce the risk of a person developing pressure sores or a detailed risk assessment in place to deal with behaviour that challenged the service.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014, Good Governance.

Some people and their relatives told us that the service was well run. A person told us that when they had had a problem with one staff member, the registered manager took action and the staff member was replaced. Another person said, "I speak to the manager often and she sorts out anything that is needed." A relative told us, "It's a well-run agency. If I need anything I pick up the phone and they always have the attitude that if there's anything we can do for you, we will do it."

People and their relatives said that if they had a query they rang the management of the service who usually responded quickly. Relatives told us they had been kept informed of any important issues relating to the care needs of their family members.

Not everyone was satisfied with the organisation of the office. One relative said, "I arranged for staff to take my aunt to the doctor. When I spoke to them in the office they didn't know anything about this." The registered manager said this issue would be followed up.

In records, we saw that incidents of alleged abuse had been reported to the relevant local authority safeguarding team to protect people from abuse and to us. This meant we were aware of incidents so we had comprehensive information to assess whether we needed to carry out an inspection of the service to judge whether it met people's needs.

When asked if they would recommend Universal Care Services, most people and relatives we spoke with all said they would. We also saw a number of compliments in records.

We saw evidence that the manager had raised the issue of the quality of care for people at the September 2017 staff meeting. The minutes of the meeting emphasised important issues such as the need to report incidents, out of hours cover, how to follow the whistleblowing procedure and the wearing of proper equipment for preventing infectious diseases. We saw evidence in staff meetings that staff being praised for the quality of their care they had provided to people. This encouraged staff to provide quality care to people. This indicated the registered manager had been proactive in trying to ensure a quality service was provided to people.

All the staff we spoke with told us that they were not always supported by office management. Some staff said that office staff needed to be more responsive to what care staff told them. Two staff said they had extra calls added on to their list of calls by office staff without them being consulted about this. When they queried this, they said office staff had pleaded with them made them feel guilty.

One staff member said they had four more calls added on to their list when they already had 14 calls to make that day. They said they started work at 6am and did not finish work until 9pm without having proper rest breaks. The staff member said that they had contacted office staff about this nine or 10 times over a week about this issue before anything was done about it. The registered manager said issue had not been raised in supervision meetings but it would be investigated and followed up with staff.

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 17 HSCA RA Regulations 2014 Good governance The quality auditing systems the provider used did not identify and act on important issues to provide people with a service that effectively met their needs.