Unique Care Network Limited

Unique Care Network Limited

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: Unique Care Network Limited is registered to provide the regulated activity of personal care. This service is a domiciliary care agency. It provides personal care to people living in their own houses in the community. It provides a service to older adults and younger adults. People had needs that related to old age and could include dementia, health conditions, and/or a physical disability. There were 43 people using this service at the time of our inspection.

People's experience of using this service:
The provider had not progressed to ensuring everyone's care plan and risk assessment had been reviewed. This meant not everyone had an accurate and up to date care plan with guidance to ensure people were safe. There had been some improvements since our last inspection in putting management plans in place to reduce risks to some people. However, this did not provide assurance that risk management processes would ensure everyone received safe and appropriate care.

At our previous inspection the provider lacked knowledge about safeguarding procedures. At this inspection we saw they still did not understood their responsibilities for keeping people safe, or for sharing information with other agencies. Staff were up to date with safeguarding training and knew how to report any concerns about people's safety.

Improvements had not been made in the recruitment of staff. The provider had not ensured safe processes were followed. Two staff had been recruited without reference checks to determine their suitability.

Some improvement had been made in relation to scheduling care call times. The provider had implemented an electronic scheduling system which we saw planned call times and monitored the duration. This also included travel time for staff between calls. However, this was in the early stages and only in place in one geographical area. Some people told us they continued to have late calls.

Quality assurance continued to be ineffective and did not pick up on the issues identified at this inspection. These included concerns with sharing potential safeguarding incidents and recruitment checks. Systems and processes were not yet in place to show how the provider was assessing, monitoring and mitigating risks. Whilst records were being reviewed, the provider did not have a system for auditing these. Leadership within the service remained unclear, roles and responsibilities were not defined. Management meetings were not recorded and there was no recorded agenda of the improvements needed or the progress being made.

The registered provider continued to lack knowledge around the regulations and legislation. They had not notified us of two incidents which they are required to do. Post inspection they used the wrong notification reports.

Rating at last inspection: The service was last rated Inadequate on 18 and 21 January 2019 and placed in

special measures.

Why we inspected: This was a planned focused inspection based on previous rating of inadequate and the requirement to re inspect services placed in special measures.

Enforcement
We identified a continued breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 around safe care and treatment and governance. We judged that the breach in safe care and treatment remains as at this inspection there was evidence that sufficient progress had been made with regard to risk management processes within the service. In addition we identified a breach in relation to staff recruitment. The provider has also a breach in relation to seeking people's consent to care and support which was not assessed at this focused inspection.

Details of action we have asked the provider to take can be found at the end of this report.

Follow up: We will continue to monitor the service as per our inspection programme.

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

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 well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Unique Care Network Limited

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
We carried out a focused inspection of Unique care Network Limited on 5 March 2019. The inspection was undertaken by one inspector.

Service and service type:

Unique Care Network Limited is registered to provide the regulated activity of personal care. This service is a domiciliary care agency. It provides personal care to people living in their own houses in the community. It provides a service to older adults and younger adults. People had needs that related to old age and could include dementia, health conditions, and/or a physical disability.

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:
This inspection was announced. We gave the service 24 hours' notice of the inspection site visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

Inspection site visit activity started on 5 March 2019. We spoke with three people and two relatives to gain

their views about the service.

What we did:
CQC was aware of incidents that were brought to the attention of the Local Authority. As part of our assessment of ongoing regulatory risk to people in the service, we looked at how the provider has mitigated these appropriately. We reviewed information from the local authority commissioners. Commissioners are people who purchase care packages and who help monitor the quality and safety of the service.

We looked at information we already held about the service such as safeguarding, complaints and statutory notifications. During the inspection we spoke with nine care staff, and four members of the management team including the registered manager. We spoke with an external training consultant. We looked at six people's care records, medicine audits, complaints records, call schedules. three staff recruitment files and records relating to the management of the service. We viewed eighteen telephone surveys carried out by the provider.

Requires Improvement

Is the service safe?

Our findings

We have inspected this key question to follow up on the concerns found during our previous inspection on 18 & 21 January 2019. At that inspection, we found people were at risk of poor and unsafe care. This domain was rated inadequate.

Safe – this means we looked for evidence that 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, lessons learned
• At our previous inspection 18 & 21 January 2019 the provider failed to ensure risks relating to the safety and welfare of people using the service were assessed and managed. People's support plans lacked information on how to deliver safe care. The provider had not always ensured they followed external advice which had placed people at risk of harm. At this inspection we found people did not receive consistent safe and appropriate care. For example, a person had been given their prescribed medicine on an evening call. However, the dose had been changed earlier that day to a reduced level. Staff had arrived early for the care call and were unaware the dosage had changed. The care coordinator informed us they had put improved safeguards in place to avoid a repeat. This consisted off family members alerting staff in sufficient time before the call about any changes to medicine doses. The care coordinator acknowledged had staff not arrived early for the call this information would have been communicated and the error avoided. The care coordinator told us this had been communicated to staff.
• We identified one person had a care call that was short. The care coordinator informed us they had identified this via their call monitoring system. We saw records that the provider had taken action via supervision with the carer and re-enforced the importance of duration of calls to all staff via a staff meeting. There had been no serious impact on the person.
• The provider had made improvements to the risks we identified at the last inspection. However, they still needed to develop a proactive system to identify risks and plan for them. At this inspection there was limited use of systems to record, manage and report concerns about risks, safety and incidents. The care coordinator showed us she was reviewing information coming in and updating changes to people's support plans. However, this meant we did not have assurances that everyone had appropriate risk assessments and support plans in place.
• The provider had invested in a new computer based care planning system. This was in use and we saw information about risks to people was evident to guide staff in the safe management of risks. However, not everyone had been reviewed or transferred to this system although the management team told us they were prioritising those people with known risks. Despite these measures being taken, they take time to be embedded and sustained to ensure people's safety. We judged that the breach in safe care and treatment remains as at this inspection as sufficient progress had not been made with regard to risk management processes within the service.

The failure to ensure risks relating to the safety and welfare of people using the service are assessed and managed was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.
• At this inspection we saw some progress had been made in relation to updating support plans with sufficient information regarding risks to people's safety. For example, we saw five people's support plans which identified risks related to pressure care, specific equipment to support a health condition and the risk of choking. These provided information to staff about the use of thickener in drinks to prevent a person choking. Use of heel protectors and a compression sock to support people's fragile skin, and how to use specific equipment to support a person's health condition.
• The management team told us they had learnt and acted on feedback from external agencies in relation to improving safety for people. For example, they had provided additional training for staff on pressure care.
• Staff told us that wound management training had improved their awareness of recognising risks. One staff member said, "When I did the training I was shocked at how quickly these can develop, and the damage under the skin".
Staffing and recruitment
• The provider at consecutive inspections in June 2015 and April 2016 and March 2017 had not ensured that recruitment checks had been fully completed to ensure that staff were suitable and safe to work. They had not fully completed checks for all staff with the Disclosure and Barring Service [DBS]. At this, our most recent inspection, we found that the situation had been repeated. Two staff had been employed without suitable references being obtained to check their suitability to work with vulnerable people. This meant systems for recruiting staff were still not safe. We shared this with the provider who took immediate action to cease using the two staff until references had been obtained.
Failure to undertake full recruitment checks is a breach of regulation 19 HSCA 2008 (Regulated Activities) Regulations 2014.

• At the last inspection the provider had not ensured there were sufficient staff deployed so that people had their care calls at times they needed. Call schedules did not include travel time for staff and calls frequently overlapped meaning people's calls were late or missed. This had impacted on people's health, safety and quality of life. Staff vacancies were not covered and existing staff were stretched in their capacity to cover calls.
• At this inspection we found the provider had implemented an electronic call system which scheduled calls and included travel time. However, this was only in place in one geographic area and therefore some people were still experiencing late calls. One person said, "One call is quite bad; I'm always waiting for them". Another person told us, "It hasn't improved or changed". The provider told us they expected to see improvements once the system was in full use. In the interim they were monitoring call times by phoning people and checking. We saw that the call scheduling system identified one call to a person had been of short duration. The impact of this was that the person did not get the support they needed for the time agreed. We saw the care coordinator had addressed this with the staff concerned and re-enforced the importance of agreed call times with all staff to avoid a repeat.
• Staff confirmed they had new rotas in advance that included travel time. A staff member said, "I know who I am visiting and I have enough time to get there and finish the call". In addition, the provider had recruited a care coordinator whose role included covering care calls in staff absence at short notice, and we saw this had been done.
• We saw evidence of the providers telephone monitoring to eighteen people the week prior to our inspection. This captured people's experiences and all but two people were happy with the times of their calls. Two people we spoke with confirmed that their call times were regularly on time. Although action was being taken, people's feedback showed they were not all receiving a consistent and reliable service.
Systems and processes to safeguard people from the risk of abuse
• At our previous inspection of 18 and 21 January 2019, we found the provider lacked knowledge around safeguarding people and escalating concerns to the appropriate agencies. At this inspection we identified two potential safeguarding incidents, which, whilst the provider had acted on these concerns, they had not

shared these incidents with the appropriate agencies. This demonstrated they continued to lack knowledge about safeguarding procedures.
• Staff confirmed they had safeguarding training and described correctly the reporting procedures if they suspected someone was at risk of harm.
• People told us they felt safe with their regular staff member visiting them. One person said, "They use the stand aid and I feel quite safe". Some people had previously not felt safe with the way staff had supported them. The provider had since taken action to check staff competencies to carry out care tasks in a safe manner.
• There is little evidence of learning from events or action taken to improve safety. For example, the lack of assessing risks related to changes in people's prescribed medicines.
Using medicines safely
• Most people managed their own medicines. Those that needed help to do so had no concerns about how the staff assisted them.
• Staff had been assessed as competent to give medicine and confirmed spot checks were made on their practice. The provider had systems in place to manage and check that medicine administration record (MAR) were signed. We saw that where topical creams needed to be applied, body maps and records were maintained. An audit of people's medicine records had been carried out two days prior to our inspection. The care coordinator told us this would be analysed and any actions needed would be followed up.
Preventing and controlling infection
• At our previous inspection 18 & 21 January 2019 people were concerned about staff practice in relation to infection prevention. At this inspection the provider confirmed that additional Infection Control training took place on 19 February 2019. Staff spoken with described safe hygiene practices and access to protective clothing. One staff member said, "We did have issues with some staff who have now left. When I am on a visit I check what the previous staff did and if they have put something in the wrong bin, I correct it". We saw that staff practices were being monitored via formal supervision sessions. Telephone monitoring was taking place to people to follow up on their concerns.

Inadequate

Is the service well-led?

Our findings

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

We have inspected this key question to follow up on the concerns found during our previous inspection on 18 & 21 January 2019. At that inspection, we found significant concerns about the lack of systems and processes to assess, monitor and improve the quality and safety of the service. People were at risk of poor and unsafe care. This domain was rated inadequate.

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.
• The registered manager continued to lack knowledge around the regulations and legislation. For example, two incidents we identified related to an error in medicines and a short duration of call. These were acted on by the provider, but had not been notified to us as is required. Post inspection the provider sent in two notifications using the wrong notification forms. This indicated that the provider was unaware of the regulatory requirements of their role.
• Leadership within the service was unclear. Whilst the provider had increased their management team by recruiting a care coordinator, roles and responsibilities were not defined. Management meetings were not recorded to reflect actions being taken in relation to the local authority action plan or the requirements of the previous inspection in January 2019. There was no recorded agenda of the improvements needed or the progress being made. The provider said they did meet and discuss issues but acknowledged this was not recorded.
• Quality assurance continued to be ineffective and did not pick up on the issues identified at this inspection. For example, in relation to staff recruitment. The provider had a previous breach related to recruitment regulations. This demonstrated that the provider was unable to sustain service improvement and unaware of the regulatory requirements of their role.
• The provider did not fully implement the agreed improvement action plan that was developed following the local authority monitoring visit.
• The provider did not yet have an audit process to demonstrate how they were monitoring call times and duration across the service.
• There was no audit tool yet in place to show that all of the support plans contained sufficient up to date information to guide carers on providing appropriate care. The care coordinator told us this was in progress; utilising the new care planning system. They were in the process of transferring all the support plans onto this system. However, not everyone had been transitioned to the new system and therefore we did not have assurance they had appropriate care plans and risk assessments in place. Whilst we noted some progress we found that systems and processes to assess, monitor and mitigate the risks to people's health, safety and welfare had not been fully established and as yet the provider had not demonstrated they could sustain

these.
This constituted a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

• We found that the provider had continued to make some progress in responding to complaints, both retrospectively and current complaints. We saw records that demonstrated the investigation, outcome and feedback to the person who had raised the complaint. However, there was no overview or analysis of patterns or trends. This meant that the registered manager was unable to use the information provided to make improvements to the service as they had no system to monitor trends.
• There had been some progress in communicating changes in people's needs. These were now allocated to the care coordinator to review and act on. For example, we saw where times of a call had been altered, this had been followed up with the service user and agreed. Staff told us they reported concerns and had an immediate response from the care coordinator. For example, where a person had been refusing personal care a new support plan with guidance had been put into place. The care coordinator told us the system had been introduced to ensure all concerns are reviewed by an allocated management member to provide a more responsive and consistent approach to people's changing needs.
• There was evidence of action and improvements since the last inspection. An electronic call system had been implemented to scheduled calls at the agreed times. We saw this included travel time and calls did not overlap.
• The provider had recently begun to monitor call times and duration. This was not fully implemented as they had only introduced the new call system into specific geographical areas. There was evidence call times and duration had been monitored. For example, we saw a short duration call was identified. Records showed they had addressed this with the staff member via staff supervision and disciplinary. Shorts calls had also been discussed in staff meetings.
*There was evidence and progress noted in relation to medication audits. We saw an audit had been completed two days prior to our inspection. The care coordinator said an analysis of these was to take place.
* Risk assessments had been reviewed and updated in the five support plans we checked.
We saw evidence that the new care planning system identified risks related to people's care and how these should be managed. For example, one person at risk of developing sore skin had a clear plan in place.

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

• The service had commenced regular meetings with people who used the service to follow up on their concerns.
• Staff meetings had been held to discuss the service and the improvements needed.
• Telephone monitoring had increased. We saw the most recent results of these were mainly positive.
Continuous learning and improving care
• The provider had implemented a training plan for all staff to ensure staff had the skills and competences to improve their practice.
• The provider had invested in external training company who had assessed and delivered training in key areas such as pressure care, moving and handling, and medicine management. The external trainer confirmed staff were engaging in this on a weekly basis and competency checks were in place. However, the provider did not have an audit in place to show how they were going to continue to monitor and sustain staff skill and training.

Working in partnership with others

• The provider had been working to an action plan with the local authority to try and address the concerns identified within the service.

•The provider was suspended from taking on further care packages until such time they could demonstrate people's care could be delivered safely.

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 People were not protected from harm due to inadequate risk management processes within the service. Regulation 12 (2) (a) (h) Regulated

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have an effective system in place to regularly assess and monitor the quality of service that people received. The provider did not monitor and mitigate the risks relating to the health, safety and welfare of people.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People who use services were not protected against the risks associated with repeated unsafe recruitment practices.