Universal Care Agency Ltd

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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?	**Inadequate**

Summary of findings

Overall summary

About the service
Universal Care Agency is a provider of community home care services providing personal care to three people aged 65 and over at the time of the inspection. 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
Quality assurance processes had not identified concerns or driven sufficient improvement relating to service quality. Records were not always complete or reflective of people's current needs. Action was not taken when people fed back about their care. The lack of robust quality assurance meant people were at risk of receiving poor quality care.

We have made a recommendation in relation to people's care records and risk assessments. This is because risk assessments and care plans were not always up to date or complete. This meant people were at increased risk of harm. However, people were supported by a consistent staff team who knew them well which reduced the risk of people receiving unsafe care.

The providers infection control policy did not provide enough guidance for staff and we found staff were not undertaking COVID-19 testing in accordance with Government guidance at the time of the inspection. Staff demonstrated they wore Personal Protective Equipment appropriately.

Improvement was needed in relation to a medicine record and the safe recruitment of staff. The registered person told us how they planned to make these necessary improvements.

The registered person told us of the difficulty they had regarding the recruitment and retention of staff. This had resulted in them having to stop providing care to some people. The registered person and staff member felt there was enough staff to support the people they currently cared for.

The provider had a safeguarding policy that was understood by staff. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 requires improvement (published 14 August 2021). There were two breaches of regulation in relation to safe care and treatment and good governance.

We issued a warning notice requiring the provider to make improvements regarding the safe care and

treatment of people and the governance of the service.

We undertook an inspection to confirm the provider met legal requirements (published 28 October 2021). Not enough progress had been made and an extension was given due to the providers circumstances. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

You can read these reports, by selecting the 'all reports' link for Universal Care Agency on our website at www.cqc.org.uk.

At this inspection, we identified one breach of regulation in relation to good governance. Due to the small number of people being supported we did not have enough evidence to make a judgement about medicines management. We found some improvement regarding risk management had been made and the provider was no longer in breach of the regulation relating to this. However, further improvement was still needed.

Why we inspected
We undertook this focused inspection to confirm the provider now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements. The ratings from the previous comprehensive inspection for those Key Questions not looked at on this occasion were used in calculating the overall rating at this inspection.

This service has been rated requires improvement for the last seven consecutive inspections. The service remains rated requires improvement. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the Safe and Well led sections of this full report.

Enforcement and Recommendations
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. We will continue to monitor the service and will take further action if needed.

We have identified one breach in relation to good governance. We made a recommendation in relation to risk management.

Follow up
We have imposed a condition on the providers registration which requires them to submit a monthly report to the Care Quality Commission on the actions being taken to ensure improvements are being made to quality and safety of the service.

We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

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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. 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 Health and Social Care Act 2008.

Inspection team
This inspection was carried out by one inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post. The registered manager is also the nominated individual for the provider organisation. A nominated individual is a person who is responsible for supervising the management of the service on behalf of the provider. This means they alone are legally responsible for how the service is run and for the quality and safety of the care provided. In this report, we will refer to them as the registered person.

Notice of inspection
We gave the service short notice of the inspection. This was because it is a small service and we needed to be sure that the registered person would be in the office to support the inspection.

Inspection activity started on 22 August 2022 and ended on 30 August 2022. We visited the location's office on 25 August 2022.

What we did before inspection
Before the inspection we reviewed the information we had received about the service, including previous inspection reports and action plans. We used the information the provider sent us in the provider information return (PIR). 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. We used all of this information to plan our inspection.

During the inspection
We spoke with one relative about their experience of the care provided. We spoke with two staff members which included the registered person and a senior care worker. We reviewed a range of records. This included three people's care records and one person's medication record. We looked at one staff file in relation to recruitment. A variety of records relating to the management of the service, including quality assurance systems were reviewed.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement.

This meant 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

At our last inspection the provider had failed to assess the risks to the health and safety of people and do all that is reasonably practicable to mitigate any such risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, the provider was no longer in breach of Regulation 12, but improvements were still needed. This is detailed further in the Well-led domain of the report.

- At our last inspection we found risk assessments or care plans had not been put in place relating to people's health conditions and support needs. Since then, the registered person had acted on the warning notice to add a lot of this information into people's care records. For example, at this inspection, guidance was available to staff in relation to catheter care, people's emotional needs and some health conditions.
- However, we still found instances where risk assessments had not been put in place regarding people's health conditions. These included conditions such cellulitis, chronic kidney disease stage three and diverticular disease. This meant staff did not have guidance about how to support people with these conditions or monitor and mitigate risks associated with them.
- Care records had not always been updated when people's needs changed. For example, on one person's care plan it stated they had a nutritional supplement. However, when we discussed this with the registered person, they told us, "I'm not sure if [Person's name] has supplements anymore, I've not seen any round the house. I've never given any. I think these were stopped after they came out of hospital." Another person's care plan stated staff must monitor a person's skin when undertaking personal care, but they no longer supported this person with personal care.
- The registered person and staff member did not have knowledge about all of the health conditions that were recorded on people's care plans. However, they told us that most of these health conditions did not affect people's daily lives or require their support. People were also supported by a consistent staff team who were confident they could recognise any changes in people's health status and would escalate any concerns to relevant professionals. This mitigated the risk of harm to people.

We recommend the provider seeks reputable guidance to ensure risk assessments are implemented and updated when people's needs change.

Using medicines safely

At our last inspection we found the provider had failed to ensure the proper and safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, due to the lack of people being supported with medicines we did not have enough evidence to make a judgement about the safety of medicines management.

● The provider supported one person to administer a topical cream to alleviate a skin condition. The medicine record provided guidance about where on the body the cream should be applied but not how frequently. This meant there was risk the cream was not being applied at the times the person needed. However, this risk was mitigated because the information was recorded in the person's care plan and they were supported by consistent staff members who knew when to apply the cream.
● At our last inspection, staff had not been assessed as competent to administer medicines. At this inspection, this had been carried out.

Preventing and controlling infection

At our inspection in May 2021, we recommended the provider sought reputable guidance to review and update their infection control policy to include up to date guidance for staff in relation to COVID-19. Not enough improvement had been made. This is detailed further in the Well-led domain of the report.

● At this inspection, the registered person showed us a COVID-19 policy they had implemented following the last inspection. This was an overarching policy and stated it should be read in conjunction alongside the other policies in the 'COVID-19 hub'. These were not in place. This meant detailed guidance about areas relating to COVID-19 such as testing and the use of protective personal equipment (PPE) was not available.
● Staff were not testing for COVID-19 in line with Government guidance. We discussed this with the registered person who told us, they would follow current guidance in the future.
● Staff told us they had access to the appropriate PPE and were able to describe wearing, aprons, gloves and masks when visiting people.
● Training had been provided regarding infection control and safe practices relating to the management of COVID-19.

Systems and processes to safeguard people from the risk of abuse

● The registered person told us there had been no safeguarding incidents since our last inspection, and we did not see any evidence which would suggest otherwise.
● The provider had a safeguarding policy in place which detailed the systems and processes to safeguard people from the risk of abuse. This was understood by the registered person and staff member.
● Safeguarding training was provided, and a member of staff demonstrated a sound understanding of how to safeguard people from the risk of abuse. They were additionally confident the registered person would act in an appropriate way if they raised a concern with them.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests

and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA. Records demonstrated people's choices and decisions were respected by staff.

Staffing and recruitment

At our inspection in May 2021, we recommended the provider sought reputable guidance on the safe recruitment and employment of staff and updated their practice accordingly.

● At this inspection, the registered person told us they had not recruited any staff since our last inspection. However, we saw one staff member was in the process of being recruited. The registered person showed us these records and further explained how they would complete the process.
● This showed the registered person would mostly recruit staff in a safe way. However, we did note improvement was still needed to ensure employment history was fully recorded. The registered person told us they would update this practice by adding the months staff had been employed at previous jobs which would eliminate the possibility of employment gaps.
● The registered person told us of the difficulties they were experiencing with the recruitment and retention of staff. This had resulted in them needing to stop supporting some people. The registered person and a staff member felt the current numbers of staff to support people were adequate.
● People received support from consistent staff. A relative told us staff knew their relative well and described them as "wonderful."

Learning lessons when things go wrong
● The registered person told us no accidents or incidents had taken place since our last inspection. However, they assured us they would use the system that was in place at our inspection in May 2021 to ensure the safety of people and ensure lessons could be learnt if necessary.

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 our last inspection we rated this key question requires improvement. The rating for this key question has changed to 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements: Continuous learning and improving care: Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At our last inspection the provider had failed to assess, monitor and improve the quality and safety of the service and the failure to maintain accurate records in respect of each person. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, not enough improvement had been made and the provider was still in breach of Regulation 17.

● Universal Care Agency has not achieved a rating of good for the last seven inspections. At our inspection in May 2021, warning notices were served in relation to breaches of Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These had not been met when we carried out an inspection in September 2021 and an extension was given due to the providers circumstances.
● Following our last inspection, the registered person completed an action plan to tell us how they would improve and by when. Improvement had been made initially but at this inspection, we found the action plan had not been updated since November 2021 and it was not clear how ongoing improvement was being met.

● Not all areas that were identified on the warning notice as needing improvement had been achieved. This included implementing quality assurance systems to improve the quality and safety of the service.This meant an effective system to check areas such as care plans, risk assessments, infection control processes and medicines was not in place. During our inspection we identified that improvement was needed in these areas.
● Records were not always detailed or up to date. This included people's risk assessments, care plans and medicine records. The registered person additionally told us the COVID-19 policy was not up to date which meant current Government guidance was not available to staff.
● The registered person had gathered the views of people using the service by sending out a quality survey approximately nine months ago. However, they told us, "In terms of doing anything with that information, I haven't done anything yet." This meant the provider had not always acted on people's feedback to make improvements for them.
● The registered person did not demonstrate a robust understanding of how to comply with regulation and sufficient improvement had not been made. Whilst we found no evidence people had been harmed,

effective systems or oversight was not in place to demonstrate a well-led service. We were not assured that if more people would be supported by Universal Care Agency in the future, they would receive high-quality or safe care.

The failure to have effective systems in place to assess, monitor and improve the quality and safety of the service and to maintain accurate and complete records was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The registered person told us they wanted to improve the service and achieve a rating of good but recognised they needed support to do this. At the time of our inspection it was not clear what this support would consist of.
● The registered person told us they undertook the majority of the roles and responsibilities for the service, including working as a care worker. This meant there was not always the time to attend to the governance of the service and ensure systems were in place to support the delivery of high-quality care and support.
● Some systems were in place to ensure the quality and safety of the service. This included staff supervision and carrying out reviews of people's care. The relative we spoke with provided good feedback about the quality and safety of the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Although the registered person expressed an ethos for providing good, high-quality care for people, a lack of effective systems meant improvements were needed in relation to ensuring care was safe and of high-quality.
● Despite this, a relative told us they were "very happy" with the service their relative received from Universal Care Agency.
● People received care from staff who knew them and enjoyed their work. The care worker spoke warmly about the people they supported. They also told us they were well supported by the registered person and they were approachable.

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
●There had been no incidents that fit the remit of the duty of candour regulation, so we were unable to assess compliance with this regulation. A duty of candour incident is where an unintended or unexpected incident occurs that result in the death of a person, severe or moderate physical harm or prolonged psychological harm. When there is a duty of candour event the provider must act in an open and transparent way and apologise for the incident.
● The provider had a duty of candour policy that required staff to act in an open and transparent way when accidents occurred. However, when we discussed this with the registered person they were not fully aware of the requirement of this regulation and told us they would improve their knowledge about it.

Working in partnership with others
● The registered person told us due to people's current situation they had no need to work in partnership with other professionals, although they explained how they had done this in the past.
● The registered person told us how they worked with people's family members where it was appropriate so good outcomes for people were achieved.

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 17 HSCA RA Regulations 2014 Good governance The failure to have effective systems in place to assess, monitor and improve the quality and safety of the service and to maintain accurate and complete records.

The enforcement action we took:

We imposed a condition.