Universal Care Services (UK) Limited

Universal Care Services Corby

Inspection report

7a Ryder Court
Saxon Way East
Corby
NN18 9EY

Tel: 01536211089
Website: www.universalcareservices.co.uk

Date of inspection visit:
21 September 2020
22 September 2020
30 September 2020
01 October 2020
02 October 2020

Date of publication:
17 November 2020

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

About the service
Universal Care Services Corby is a domiciliary care agency that provides personal care to people in their own homes. At the time of inspection there were 135 people receiving personal care.

People's experience of using this service and what we found
There were not enough staff employed to ensure people's care was delivered at the time they needed. People had not always received their care at planned times or length of time for their care. Due to the Covid pandemic staffing levels had been erratic as some staff had had to isolate at short notice. Rotas that had been made in advance had been changed constantly to ensure people received their care.

New staff were being recruited using safe recruitment practices.

People's risks were assessed, and the care plans described how staff would mitigate these known risks. However, staff need to have time allocated to update themselves with these.

The provider recognised the need to improve the communication with staff, people using the service and their relatives. People and their relatives were asked for their feedback about the service and these were used to make improvements to the service.

Staff had received training in and followed the provider's infection control procedures.

People were protected from the risks of abuse or poor care as the provider had systems in place to identify, report and learn from safeguarding incidents.

Staff received training in the safe management of medicines and their competencies had been checked. Regular medicines' audits informed the manager of any issues which were rectified in a timely manner.

The provider and registered manager had implemented systems and audits to enable them to identify where they needed to make improvements.

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 23 July 2019) and there were two breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we only looked at the breach relating to staffing; enough improvement had not been made and the provider was still in breach of this regulation.

Why we inspected

The inspection was prompted in part due to concerns received about staffing and management oversight. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the safe and well sections of the full report. We found no evidence during this inspection that people were at risk of harm from this concern.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Universal Care Services Corby on our website at www.cqc.org.uk.

Enforcement
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.

We have identified a continued breach in relation to staffing at this inspection. We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. 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?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Universal Care Services Corby

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 Care Act 2014.

Inspection team
The 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, flats and specialist housing.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who commissioned care at the home and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection

We spoke with seven people who used the service and nine relatives about their experience of the care provided. We spoke with seven members of staff including one representative for the provider, the registered manager, compliance officer, the care co-ordinator and care staff.

We reviewed a range of records. This included rotas and 18 people's care records and five medication records. We looked at seven staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures 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 the last inspection this key question was rated as requires improvement. At this inspection 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.

At our last inspection on 4 July 2019 the provider failed to have sufficient staff to provide people's care, the provider failed to be compliant with Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

At this inspection we found that although the provider had made significant improvements to the way they deployed staff, due to staffing issues caused by the pandemic, people continued to not receive their care as planned.

Staffing and recruitment

- People had not always received their care at planned times. People received their meals, medicines and personal care at irregular times, sometimes very close together or far apart. This put people at risk of not eating regularly, not receiving all their doses of pain relief or having sore skin from soiled clothing. One relative told us, "In [Name's] notes you can see in the mornings the carers come at 6.30am one day and 9am the next. [Name] needs their pain killers when they wake up, they have to wait."
- People did not always receive their commissioned length of time for their care. Staff were allocated travel time between calls, but due to the pandemic, staff gave short notice for absences due to isolation. One member of staff told us, "The rota changes all the time with extra calls." This led to staff rushing and cutting call times short to be able to get to the next person. People's evening calls had become very late. For example, some people should have received calls at 10pm, but did not receive care and support until 11.30pm.
- The registered manager had contingency plans to cover calls themselves, as well as deploying staff from the office. However, due to the pandemic, when staff had to unexpectedly self-isolate the contingency plan failed.
- People did not always receive care from staff they knew, some staff did not have a regular rota. The registered manager told us, due to the Covid pandemic staffing levels had been erratic due to staff having to shield or isolate at short notice. Rotas that had been made in advance had been changed constantly to ensure people received their care.

There were not enough staff employed to ensure people's care was delivered at the time they needed. This was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had recognised people were not receiving their care as planned. They had prioritised recruitment, which had led to 11 new staff being recruited, inducted and trained. . The new staff were due to start their supervised visits which the provider felt would "go a long way to easing the staffing problem."
● Staff were recruited using safe recruitment practices whereby references and their suitability to work with people who used the service were checked.

Preventing and controlling infection
● The provider was following national infection prevention guidelines. Staff had easy access to personal protective equipment.
● Staff had received training in infection prevention procedures.
● Staff followed the provider's infection control procedures. People told us staff used face masks, gloves and aprons when giving care. One person told us, "The carers wear masks, they are very professional."

Assessing risk, safety monitoring and management
● People's risks were assessed, and the care plans described how staff would mitigate these known risks.
● Staff had access to people's care notes on their phones and could check what care people needed before they visited. However, some people told us new care staff did not always read the care plans. Two people told us of their frustration of having to constantly explain the care they needed to new care staff. One relative told us, "The time the carers are here is supposed to be respite time for me, but I spend most of my time explaining to new care staff what needs doing."
● Some people had not had their care reviewed in the last year. The provider was introducing a new system for care planning, which would involve everyone receiving a review of their care.

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risks of abuse or poor care as the provider had systems in place to identify, report and learn from safeguarding incidents.
● Staff received training in safeguarding vulnerable adults. Staff demonstrated they understood their responsibilities to protect people from the risks of harm and abuse. Staff told us they reported concerns to the manager.
●The provider's safeguarding policy guided staff on how to raise referrals to the local authority safeguarding team.
● Staff were aware of the whistle blowing policy and who to contact should they feel it necessary.

Using medicines safely
● People who had their medicines dispensed in blister packs received their medicines safely as staff followed the provider's policies and procedures. However, since the pandemic, not all medicines were being dispensed in blister packs. This had led to some confusion where people's medicines were in boxes. The registered manager was updating their system to incorporate all prescribed medicines.
● Staff received training in the safe management of medicines and their competencies had been checked.
● Regular medicines' audits informed the manager of any issues which were rectified in a timely manner.

Learning lessons when things go wrong
● People could be assured lessons were learnt from accidents and incidents. For example, improving the on-call system to ensure all calls were logged and responded to in a timely way.
●The manager used the experience of incidents to improve care. Each incident was reviewed with the staff team to ensure staff are aware of any ongoing risks or changes to care.

Requires Improvement

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question remained the same.

Requires improvement: This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At this inspection we found that although the provider had made significant improvements to the way they managed and monitored the quality of the service, staffing issues caused by the pandemic meant people did not receive their planned care at the times they needed.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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

- The provider supported the registered manager in the running of the service. Staff received support they needed from the provider to keep them safe during the pandemic.
- The provider and registered manager told us staff had shown great loyalty and compassion in providing extra calls at short notice. The registered manager recognised the extra work staff had undertaken to ensure all people received their care.
- The provider and registered manager had implemented systems and audits which provided a clear picture of their service. The outcomes from audits had been analysed and action plans were in place to make improvements.
- The manager understood their regulatory requirements to report incidents and events to CQC, our records showed these had been submitted as required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The registered manager arranged for people and their relatives to feedback about the service through regular phone calls. The feedback was acted upon and used to make improvements to the service. For example, where possible to have regular care staff.
- People told us they appreciated the support they received during lockdown. People who had to shield were being supported by a restricted number of staff. People who were continuing to shield continued to be supported by phone from office staff. The registered manager had supplied food parcels to people during the lockdown.

Continuous learning and improving care; Working in partnership with others

● The provider and registered manager were continually looking for ways to learn from incidents and improving care. Staff had raised concerns about the irregular rotas. The provider told us when there was enough staff, they planned to ensure staff had regular rotas.

● The provider and registered manager worked closely together to assess the service and look for ways to improve the care people received. They recognised the need to allow time for staff to read care plans and improve the communication with staff, people using the service and their relatives.

● The provider was working closely with the commissioners to manage new packages to ensure they had enough staff and regular rotas to manage new packages of care.

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 18 HSCA RA Regulations 2014 Staffing There were not enough staff employed to ensure people's care was delivered at the time they needed. This was a continued breach of Regulation 18 (1).