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

Summary of findings

Overall summary

Universal Care Limited is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults, people living with dementia, mental health impairments, physical disabilities, sensory impairment and younger adults. The domiciliary care agency office is situated within the Cosham area of Portsmouth.

This inspection was undertaken on the 6 and 12 March 2018. Not everyone using Universal Care Limited receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of the inspection 18 people were receiving a personal care service from Universal Care Limited.

This service was in Special Measures as the well led section of the report had been rated inadequate following two consecutive inspections. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements had been made and it is therefore no longer rated as inadequate overall or in any of the key questions. Therefore, this service has now been removed from Special Measures as per CQC's Special Measures Policy.

Following the inspection in May 2017 three breaches of regulations were identified. At this inspection we found action had been taken to become compliant with these although further work was required to ensure the newly introduced quality assurance procedures were embedded in practice and identified all areas for improvement we found during the inspection.

The service did not have a registered manager at the time of the inspection. 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 2008 and associated Regulations about how the service is run. The provider had appointed a person to manage the service who had applied to become registered with the Care Quality Commission. Their application was being assessed at the time of the inspection.

Some risks to people had been individually assessed and risk management plans were in place to mitigate these risks. However, records did not show that these had been reviewed and these did not cover all risks which had been identified during the assessment process.

At the time of the inspection staff were not administering oral medicines to anyone. Where staff were prompting people to take medicines recording systems were not in place. We have made a recommendation that the service follows best practice guidance and introduces appropriate recording tools for the administration and prompting of medicines including prescribed topical creams.

We received positive feedback from people about the service. People who used the service expressed satisfaction and spoke highly of the staff and provider's representative. All the people and family members who were asked if they would recommend the service to others said they would.

People and their families told us they felt safe. Staff understood their safeguarding responsibilities and knew how to prevent, identify and report abuse.

Safe recruitment practices were followed and appropriate checks were undertaken, which helped make sure only suitable staff were employed to care for people in their own homes. There were sufficient numbers of care staff to maintain the schedule of visits and ensure a high level of continuity for people. Staff completed an induction programme and were appropriately supported in their work. Staff had received relevant training and arrangements were in place to refresh this regularly.

There was an infection control policy in place and protective equipment such as gloves and aprons were provided to staff to minimise the spread of infection. People confirmed that safe management of infection control risks were adhered to.

People who used the service felt they were treated with kindness and said their privacy and dignity was respected. Staff knew the people they provided care to well and understood their physical and social needs. Staff were able to describe how to meet people's needs effectively. Staff supported people to access healthcare professionals when needed.

Staff, the manager and the provider's representative knew how legislation designed to protect people's rights affected their work. They always asked for consent from people before providing care.

People and, when appropriate, their families were involved in discussions about their care planning and given the opportunity to provide feedback on the service. They were also supported to raise complaints should they wish to.

At the time of the inspection no one using the service was receiving end of life care. However the manager assured us that people would be supported to receive a comfortable, dignified and pain-free death.

People and their families told us they felt the service was well-led and were positive about the provider's representative who understood the responsibilities of their role.

We identified one breach of Regulations. 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 always safe.

Not all individual and environmental risks to people and staff were assessed and plans put in place to mitigate those risks.

Care staff had received safeguarding training and were clear about their safeguarding responsibilities. The manager had not identified a safeguarding concern which we told them they should report to the local authority safeguarding team.

There were safe medication administration systems in place and people received their medicines when required, although records of prompting and administration were not always kept.

Recruitment procedures were followed to ensure staff were safe to work with people. Staffing levels were sufficient to take account of people's needs.

There were processes in place to enable the provider to monitor accidents, adverse incidents or near misses. These helped to identify any themes or trends, allowing timely investigations, potential learning and continual improvements in safety.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider's representative and manager were occasionally supporting people however they had not completed all their training. Supervisions and spot checks had not always been completed. Staff received an appropriate induction and on-going training to enable them to meet the needs of people using the service.

There was no process to seek permission to gain information about prescribed medicines or past medical history from people's medical doctors. People were supported to access health professionals and staff acted when new medical needs were identified.

Staff sought consent from people before providing care and

followed legislation designed to protect people's rights. People received consistent care from staff they knew and were supported with eating and drinking where required.

Is the service caring?

Good

The service was caring.

People said that staff treated them with kindness.

People's dignity and privacy was respected at all times.

People were encouraged to remain as independent as possible.

Is the service responsive?

Good

The service was responsive.

Care plans provided relevant information for care staff however where specific information was not available at the time of assessment action had not been taken to obtain this subsequently.

People were pleased with the care and support provided by staff as it met their individual needs.

The manager sought feedback from people using the service and had a process in place to deal with any complaints or concerns.

At the time of the inspection no one using the service was receiving end of life care. However the manager assured us that people would be supported to receive a comfortable, dignified and pain-free death.

Is the service well-led?

Requires Improvement

The service was not always well led

There were systems in place to monitor the quality and safety of the service provided. However these were not yet fully embedded in practice and had not identified areas of concern we found during this inspection.

People and their families were positive about the service and told us they were very satisfied with the organisation and the running of the service.

Universal Care Agency Ltd

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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was announced; we contacted the provider the day prior to our inspection as it was a domiciliary care service and we needed to be sure key staff members would be available.

This inspection was conducted on the 6 and 12 March 2018 by two inspectors.

Before the inspection, we reviewed previous inspection reports and notifications we had been sent by the provider. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with three people who used the service and two relatives of people who used the service, by telephone and visited three people in their own homes. We spoke with the provider's representative, the manager and five care staff members. We looked at care records for seven people. We also reviewed records about how the service was managed, including staff training, support and three recruitment records, complaints records, compliments and audits completed by the management team.

Requires Improvement

Is the service safe?

Our findings

At our previous inspections in December 2016 and May 2017 we found that safe recruitment procedures had not always been followed which had placed people at risk. This was a breach of Regulation 19 of the Health and Social Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found action had been taken and the service was no longer in breach of Regulation 19.

Appropriate arrangements were in place to ensure that the right staff were employed at the service. An audit tool was in use to help ensure no staff commenced employment before all essential checks had been completed. Staff recruitment records for three members of staff showed the registered provider had operated a thorough recruitment process in line with their policy and procedure to keep people safe. Relevant checks were carried out before a new member of staff started working at the service. These included the completion of Disclosure and Barring Service (DBS) checks, which would identify if prospective staff had a criminal record or were barred from working with vulnerable people. Staff files included application forms, health declarations and references. On viewing these records we saw that any gaps in a staff member's employment history had been investigated and outcomes recorded. This meant that the service was aware of what the staff members had been doing during these times and whether that impacted on their suitability for employment.

Some risks to people had been individually assessed and risk management plans were in place to minimise these risks. However, records did not show that these had been reviewed and these did not cover all risks which had been identified during the assessment process. For example, where people had specific known medical conditions such as diabetes there was no nutritional or medical needs risk assessment. Where a person was receiving a blood thinning medicine there was no risk assessment to guide staff to the increased risks this presented for the person should an injury occur. The manager showed us a new integrated assessment, care and risk planning document that was to be introduced in April 2018. This document would link identified needs to a risk assessment and should therefore help ensure all risks would be identified and formally assessed.

People's home and environmental risk assessments had been completed by the manager to promote the safety of both people and care staff. However, not all identified risks had been assessed. For example, one person had a dog. The risks this may pose to care staff had not been assessed. Another person smoked cigarettes and although it was documented that they were not always safe when smoking there was no risk assessment and management plan to ensure the safety of the live in care staff who were therefore at high risk. It was not clear that other environmental risk assessments had been kept under regular review.

Prior to the provision of a care service the manager undertook an assessment of the person's needs to determine if the service could meet these and identify risks to people or staff. Copies of completed assessments were seen within care files. Overall these had been fully completed although we noted some gaps where information had not been recorded. The manager said this information had not been available at the time of assessment; however, they had not subsequently acted to gain this information. For example, for one person the section related to allergies was left blank and for another it stated they were allergic to

antibiotics without specifying which ones. The absence of specific information meant all risks could not be identified and action taken to mitigate these risks.

Within care files there was listed information about the person's medical conditions, however there was not any further detail regarding risk assessments for these conditions or how to manage them. For example, one person was stated to be at 'high risk of infections', however the care plan did not say to which type of infection or how this risk could be minimised. Another person's care file identified they had a number of long term health conditions; however, there was no detail as to how these may affect the person.

The failure to complete, and regularly review, assessments of the individual and environmental risks to people is a breach of Regulation 12 of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.

There were sufficient numbers of staff available to keep people safe. Staffing levels were determined by the number of people using the service and the level of care they required. The manager told us new care packages were only accepted if sufficient staff were available to support the person. The manager said "We would never take on more packages than we can cope with." Universal Care Limited had an 'on call system' in place to cover short notice staff absences and respond to any concerns that occurred out of office hours. We saw a staff monitoring visit had identified that staff were arriving late for some calls as they had not been allocated time to travel from their previous care call. Action had been taken to rectify this. The manager told us traveling time was now always allocated. This meant that staff were able to get to care calls in a safe and unhurried way. Staff were very clear that they were not rushed to get to visits and that they had sufficient travel time allowed. Staff told us they had enough time to visit. One staff member said "There is loads of travel time, I never feel rushed." Another said "I haven't felt rushed at all, which is great." People confirmed that staff usually arrived at approximately the correct time and always stayed for the full length of time allocated.

People told us they felt safe. People's comments included, "I feel safe with the staff" and "They [staff] know what they are doing." Family members also told us they did not have any concerns regarding their relatives' safety. We saw a family member had written in a complements card "I feel total trust when [name of relative] receives her care".

During the inspection we were concerned that the manager had not identified a safeguarding concern which occurred during a meeting being held with health and social care staff. We informed the manager they should be reporting this to the local authority.

The manager was able to explain the action they usually took when a safeguarding concern was raised. In August 2017, the local authority safeguarding team requested the provider to investigate a safeguarding concern. The investigation was comprehensive and concluded that staff had acted appropriately. Staff protected people from the risk of abuse and were clear about their safeguarding responsibilities. Staff knew how to keep people safe in their own homes, and described the importance of locking doors, jumbling key safe numbers and checking if there were any other problems. Training records showed that all staff had completed safeguarding training within the previous year.

The manager told us that at the time of the inspection staff were not administering oral medicines to anyone. This was confirmed by care staff we spoke with who told us they prompted some people to take their medicines and recorded this within daily logs. People's care plans included information as to the support people required with their medicines and who was responsible for collecting prescriptions and disposing of unused medicines. In one file it was listed that staff should apply topical cream to the person's

body but it did not state which cream should be used or where this should be applied. A relative told us how staff always remembered to apply several prescribed topical creams; however, these were not being recorded as being applied. Medicines administration records were not in place although these were prescribed topical creams.

We recommend that the service follows best practice guidance and introduces suitable recording tools for the administration and prompting of medicines including prescribed topical creams.

All care staff undertook medicines management eLearning and the manager undertook an assessment of their competency following completion of the learning module.

The provider had an infection control policy in place and staff undertook training in this area. Training records showed all staff had completed infection control eLearning in the previous year. Protective equipment, such as gloves and aprons, were provided to staff to minimise the spread of infection. People and relatives told us that staff always wore gloves and aprons when completing care tasks and washed their hands. One staff member told us, "We always have access to gloves and aprons which we always wear when providing personal care."

The provider encouraged staff to report concerns and safety incidents. There were processes in place to enable the provider to monitor accidents, adverse incidents or near misses. The manager informed us there had not been any such incidents since the previous inspection; however, should these occur they said they would undertake a comprehensive, timely investigation, notify relevant professionals such as the local authority and the Care Quality Commission and identify any potential learning or improvements required to promote safety.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in May 2017 we found the provider had failed to have an induction programme in place which prepared new staff for their role and had not been providing staff with ongoing training to ensure they had the necessary skills and knowledge to meet people's needs safely. This was a breach of Regulation 18 of the health and Social Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found action had been taken and staff were now receiving an appropriate induction and ongoing training.

The provider's representative and manager told us they would, on occasion, undertake some care calls if required, such as due to staff absence. A person confirmed that the provider's representative sometimes supported another staff member when two staff were required to meet a moving and handling need. However, neither the provider's representative or manager had completed or updated all of their training as detailed in the provider's procedures.

People were supported by care staff who had received an effective induction into their role, which enabled them to meet the needs of the people they were supporting. Each member of care staff had undertaken an induction programme, including a period of shadowing (working alongside) a more experienced member of care staff. Following completion of the shadow shifts, the manager told us they asked the senior care staff member if the new care staff member was competent before they were allowed to work on their own. If necessary, additional shadow shifts could be arranged. Care staff confirmed that they received an induction before working independently.

The provider had a system in place to record the training that care staff had completed and to identify when training needed to be repeated. This showed that care staff had completed appropriate training to meet people's needs safely. All the care staff we spoke with told us that they felt they had received appropriate training to help them provide effective care for the people they supported. Care staff said the online training was very good, but the amount of practical training was limited. One said "I think we should have a bit more hands on training, but the online training is very good." A care staff member also said that the manager was very supportive in helping them to receive additional training in particular areas of need. Whilst most training was provided via eLearning on a computer, the manager had undertaken a train the trainer course in 2017 for moving and handling and records showed they undertook a practical assessment of care staff following the computer training. Should people have specific health care needs the manager stated additional training to meet those needs would be organised by health staff. For example, they told us two care staff had received training to support a person who received their nutritional requirements via a tube directly into their stomach.

Care staff felt they were appropriately supported in their role. Care staff confirmed that they received one-to-one supervision with the manager. Additionally, the manager or a member of the management team completed 'spot check' visits approximately every three months or more frequently if required. Spot check visits are where a member of the management team calls at a person's home just before or during a visit by a member of care staff. This is so that they can observe the member of care staff as they go about their duties and ensure that they are meeting their standards and expectations. Care staff told us they received

regular supervisions with the manager. All care staff told us they had also had a 'spot check' recently when working in the community. Staff confirmed they were provided with feedback from the 'spot check' and felt this was a useful and worthwhile exercise. Records of supervisions and spot checks showed that these had not always been completed as per the provider's policy of four formal supervisions and four spot checks per year. The provider stated they were aware of this and an additional senior staff member was now involved in undertaking some of these. Staff employed for longer than 12 months had also received an annual appraisal of their overall performance.

People and their families told us they felt the service was effective and that care staff understood people's needs and had the skills to meet them. People and their families described the care staff as being well trained and said they were confident in the care staff's abilities. A family member told us "Yes, they seem to know what to do and how to do it". One person said, "Anything that I want done, they'll do it." Another person told us care staff were willing to provide extra help if they could, for example by asking, 'Is there anything else I can do before I go?" A written compliment from a person read, 'All of my carers are superb, they give excellent care'.

There was no process in place to seek people's permission to gain information about prescribed medicines or past medical history from the person's GP. This meant the service and care staff may not have all necessary information to provide effective care and meet people's health needs. Staff responded appropriately to meet additional medical needs. A family member described a scenario where a care staff member had rung them about concerns for a person. We were told the care staff member had been clear in explaining what they had done and what they were going to do. They had also kept the family member updated when the service user was later transferred to hospital. One person told us the service had identified a need for an occupational therapist (OT) to review the way they were supported to meet a personal care need. They told us the service had arranged for a referral to the local authority OT.

People told us that they received consistent care from staff they knew and care staff were assigned regular visits each day. Office staff produced a weekly staff rota to record details of the times people required their visits and the staff that were allocated to them. The provider told us they had introduced photographs of allocated care staff to help people know who to expect. These were seen on allocated rotas viewed. These were then sent to the person so they knew who would be supporting them at each visit. People confirmed that care was provided as detailed on rotas.

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.

The manager and care staff demonstrated an awareness of the MCA and had an understanding of how this affected the care they provided. Since the previous inspection they had introduced a Mental Capacity assessment form which was completed for all people receiving a service. This followed best practice guidance. Where this found people lacked capacity to consent to their care plan, a best interest decision involving relevant people had been undertaken. In one care file it was recorded that a relative had a Lasting Power of Attorney to make decisions on behalf of the person. The manager stated this was for finances and health and welfare; however, they had not requested or seen a copy of the legal documents to confirm this. This meant that they could not be assured as to who was legally able to make decisions on behalf of the person.

People and their families told us that staff asked for their consent when they were supporting them. One person also told us "They even ask if it's ok for them to use my toilet", they added "I always say yes so they know its ok but they still ask every time". Staff were clear about the need to seek verbal consent from people before providing care or support.

Most of the people we spoke with said they or a relative prepared their meals. Those for whom staff prepared meals were happy with the way this was done and told us they were always given a choice about what they wished to eat and drink. One person said, "I always have a cooked breakfast, I'm sure if I said I wanted something else they would do that." Another person told us, "They ask what I want and then get that ready for me." Care plans contained information about any special diets people required and staff were aware of people's dietary needs.

Staff worked well with other organisations to ensure they delivered good care and support. The manager liaised with other organisations to ensure people received effective care provision and support. People were supported to use technology and specialist equipment to meet their care needs and to support their independence where appropriate. Where equipment was required, the provider's representative was aware of how to access equipment.

Good

Is the service caring?

Our findings

People and their families could not praise the service enough and consistently told us about the excellent care provided by the staff and management team at the service. People's comments included, "The team of carers are lovely and very consistent" and "I trust them, you could ask them to do anything, they are so kind." One family member said "The staff are really good, always happy and we know who is coming". When people and their family members were asked if they would recommend the service to others, each confirmed they would.

The service had received a number of written compliments over the last 12 months from family members who praised the care that had been received. One written compliment read, 'They go out of their way to please you'. Another written compliment stated 'Both [staff name] and [staff name] go out of their way, they are outstanding, very kind, very good with [name of relative cared for]. A third stated '[Name of person] face lights up when they come in.'

The provider's representative told us about occasions when staff had identified additional needs for people and ensured these were met. For example, when one person had been unwell and unable to go out for food and had no money to purchase food, the service purchased sufficient food for the coming week and did not reclaim the money. Staff also undertook unpaid additional visits to check on people they were concerned about such as if the person was unwell or there were concerns about the person's safety.

People were cared for with dignity and respect. A family member told us that all personal care was provided with consideration to [the person's] dignity. They explained how staff always used a towel to keep the person covered whilst personal care was being provided. A person said, "They [staff] treat me with dignity and respect; I have never had to complain." Staff understood the importance of maintaining people's privacy and dignity when providing them with personal care. They described how they would close curtains or doors and ensure people were covered when having a wash. In 2017, the provider completed a survey of people's views about the service they received. Everyone who responded confirmed that their privacy and dignity was always respected by care staff.

People and their families told us that they received good person-centred care and support. People and their family members spoke highly of individual staff members and confirmed they had a good rapport and relationship with the staff who supported them. People told us that they looked forward to the visits from the care staff. One person said, "I would not be without them. One of them brings me fish and chips every week which I love, I cannot speak highly enough about them". A second person told us, "They always ask if there is anything else they can do". A family member said, "The care staff do not rush the care calls and always do a good job." We found there was very limited detail of the person's background and personal histories including their culture or ethnicity within care files. However, due to the high level of continuity of care staff this had not resulted in impact on people.

A family member described an instance where the service had worked with them to ensure that a person received the same care staff member for their weekly bath. The provider's representative told us that, to aid

continuity, it was likely that people would have the same care staff for four or five days out of seven each week. They explained that they had recognised that this was important to people and had worked hard to ensure rosters met people's needs. People told us and allocation rosters confirmed there was a high level of consistency in the allocation of care staff. This meant people received care from staff who knew them and how they liked to be cared for. Where requested, arrangements would be made to suit people's preferences. People told us that where they had requested a specific gender of staff member to support with personal care this was always respected. For example, one person only wished to have male care staff, which the service was able to accommodate.

People were encouraged to be as independent as possible. A person told us how staff supported them to continue to attend to their own personal care needs where they were able to do so and did not "take over". A staff member said "I always encourage my clients; I would make sure that I don't take over." People's care plans contained some information about what people could and couldn't do for themselves. Additionally, due to the consistency of the staff, they knew the people they were supporting well and the level of support each person needed.

People were supported to express their views and to be involved in making decisions about the care and support to be provided. This was achieved through regular reviews of the person's care which were completed by a member of the management team, the person and, where appropriate, the person's family member.

Information regarding confidentiality, dignity and respect formed a key part of the induction training for all care staff. Confidential information, such as care records, was kept securely within the registered provider's office and only accessed by staff authorised to view it. Any information which was kept on the computer was also secure and password protected.

Good

Is the service responsive?

Our findings

People were assessed before their care started to ensure that their needs could be met appropriately and effectively. This allowed the person the opportunity to discuss any care preferences they had, such as times of calls, gender preferences of staff and religious or cultural needs they had. The information gathered from the initial assessment was used to inform the person's care plan. Care plans included information in relation to people's communication needs, personal care needs, health needs and dietary requirements. The manager told us information was also gained from health and social care professionals and family members.

Care plans described the care each person required at each visit. A care plan review sheet had been introduced which showed that review meetings were occurring. The manager said they also telephoned people at regular intervals especially when care had been commenced to see if they were happy with the way the service was meeting their needs. However, records of these telephone calls had not been maintained which meant that had any action been required there was no record to show this had occurred.

Care staff told us they were always informed about the needs of the people they cared for and could consult care plans, which were held in people's homes and the agency's office when required. Care staff could also access care plans and information about people via a smart phone app. Care staff were kept up to date about any change in people's needs from the previous daily records, directly from the people and their families, and from the office staff and management team. Care staff recorded the care and support they provided at each visit and a sample of the care records demonstrated that care was delivered in line with people's care plans and their wishes.

People told us that care staff were responsive to their needs and were adaptable if their needs changed. A family member told us care staff had been able to provide additional care to enable them to attend a medical appointment. Family members talked about the agency staff responding swiftly to changes in people's needs. The provider told us how care staff had undertaken additional visits when they were concerned about a person who had been unwell. Care staff described occasions where a person had fallen, been unwell or they had to wait for an ambulance to attend. Care staff told us they were able to contact the office for support and someone in the office rearranged their next scheduled visits so that subsequent people were kept informed. This meant that in an emergency people would receive the support they required and subsequent people would be kept informed about any delays or alternative care organised.

People were encouraged to provide feedback and were supported to raise concerns if they were dissatisfied with the service. Feedback was also gathered on an informal basis when the management team met with people in their own homes, during review meetings or via telephone or email contact. The provider also sought feedback from people and their families on a formal basis annually through the completion of quality assurance questionnaires which were sent to people and their families where appropriate. We saw that the last quality assurance assures questionnaires were sent in August 2017. The results of these showed that people using the service and their family members were happy and satisfied with the overall quality of the service provided and showed the service had consulted with them. People described the care staff and

provider's representative as approachable and all said they were confident that any feedback they gave about the service would be acted upon.

The service had a policy in place to deal with complaints, which provided detailed information on the action people could take if they were not satisfied with the service being provided. People and family members knew how to complain if they needed to and were provided with written information in relation to this. One person said they had made a complaint and were very satisfied with the response from the manager and the outcome. The manager was able to explain the action that would be taken to investigate a complaint if one was received. We reviewed records of complaints received since the previous inspection in May 2017. Full records had been kept and these showed that complaints were investigated and responded to appropriately, including a written explanation of the investigation and an apology.

Although no one using the service was receiving end of life care, the manager provided an assurance that people would be supported to receive good end of life care and support to help ensure a comfortable, dignified and pain-free death. Furthermore, they told us that they would work closely with relevant healthcare professionals and ensure staff were appropriately trained.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in May 2017 we found that the provider had failed to operate effective systems and processes to monitor the overall quality and safety of the service. This was a breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection we found the provider had introduced new systems to monitor the service; however, these were not yet fully embedded in practice and were not yet ensuring people received a safe service.

We identified areas where the monitoring tools had not been appropriately completed meaning areas for improvement had not been identified and action to ensure these improvements were made had not been followed up on. For example, the manager had undertaken a review of care planning and related documents. However, this had not identified gaps within some assessments and where additional risk assessments were required. For one person their assessment stated they were allergic to antibiotics but it was not specified which ones, for another person the allergies section was left blank, as were some other parts of their assessment. We discussed this with the manager who stated they had not been able to obtain that information at assessment. However, the audit had not identified this missing information meaning no action had subsequently been taken to seek the missing information. Within one of the care plans viewed we saw that a Deprivation of Liberties (DoLS) assessment screening tool had been completed. Other information confirmed that the person had capacity to understand and consent to care and was not under 24 hour care or supervision. When we asked why this was in the care plan, the manager told us that this was a 'trial'. They removed the document from the care plan agreeing that it was not appropriate. We discussed these issues with the provider's representative who agreed that there needed to be a second staff member involved in aspects of the quality assurance procedures. The provider had commissioned an external consultant to undertake a review of the service and help drive improvements.

We also identified that some other aspects of the service's management had not been completed as per the provider's procedures. There was a print out from 'Social Care TV' in each staff member's file showing the percentage achieved in different areas of training. The provider's representative told us that the pass mark for these training courses was 70%. One of the staff files that we looked at showed that the staff member had not met this pass rate in two areas of training. The provider's representative who told us the staff member would re-sit this training. However, we were not assured that if we had not identified this that it would have been noted and action taken to ensure the staff member met the required standard to complete the training.

The manager was undertaking formal 'spot checks' on care staff. We viewed the records in relation to these. However, the recording tool in use was not being correctly completed and did not identify when further action was required. For example, one spot check stated that there were no infection control concerns; however, the staff member had had to be prompted to use personal protective equipment. There was no follow up to ensure that the staff member was now remembering to use this essential equipment for their own and the person's protection. Another question on the form was answered with a statement which did not relate to the question. The provider's representative acknowledged a need to make improvements in the recording and reviewing of monitoring processes.

There was no process in place to monitor if staff arrived for all care calls. The process in place relied on people or their relatives to contact the office if staff failed to arrive. The manager told us this had occurred on two occasions since the previous inspection. Information provided by the manager showed that this had been addressed with the staff member concerned; however, there had not been any review of the service's procedures to help prevent this occurring in the future. For example, in March 2018 a call was missed as a staff member forgot that they had said 'yes' to an additional call. A review of procedures should have identified a need for a more robust system to prevent recurrence of missed calls.

Care staff records of care were completed in bound books which were returned to the agency office when completed. This meant that these could remain in people's homes for prolonged periods before being returned to the office. For example, one book viewed in a person's home had been in use since the end of October 2017, in excess of four months. This meant that the provider did not have a system to formally review the record books and care provided in a timely way and discrepancies between care provided and care required would not be promptly identified. This was discussed with the provider who acknowledged there was a delay.

Services are required to have a manager who has registered with CQC and who we have assessed as being suitable to manage the legal responsibilities associated with running of the service. The service had not had a registered manager since 8 July 2016. However, the manager had applied to register with the commission and this process is ongoing.

A representative of the provider, who was a director of the company, was present for the majority of the inspection. They were receptive when we identified areas for improvement and it was evident from their responses that they were in day to day contact with the operation of the service. It was also clear they were keen to make improvements for the benefit of the service. The provider's vision and values were focused on the importance of putting the person at the centre of what they did and promoting independence. The provider's representative told us they were part of the local care providers association which kept them up to date with changes relevant to their service. Policies and procedures were purchased from a national organisation and individualised where needed to reflect the service. The provider's representative told us they received updated procedures on a regular basis.

People and their families told us they were very satisfied with the organisation and the running of the service. People we spoke with told us about the care and support they received from the management team and the staff. People and their families comments included, "I talk to [management] a lot, he's very good, they know to contact me. I have no problem with them, I'm very happy" and "I get dialogue with them [management], any issues; they ring and let me know straight away." One person told us how the provider's representative had supported them to meet up with a group of friends for an important lunch. They told us without the offer of transport they would not have been able to attend. People and their families all said they would recommend the service to another person who needed support.

Staff also told us they felt that the service was well run and managed and they enjoyed working for Universal Care. One staff member said "I enjoy it, I get a nice feeling working with the elderly." Another said "I like this job, the staff are nice, all of the clients are lovely." Whilst a third commented "It's a really good company to work for." Staff said that historically the service's management was 'hit and miss', however this had improved over the past year. Staff reported feeling supported by management and felt that the manager and officer staff were supportive and open. All staff spoken with were very complimentary of the manager, office staff and directors. For example, they said "If I have a problem, it gets sorted straight away. If something needs to be done, I know it will be." And "I've never had a problem. They [management] are all very supportive."

As previously stated within the report, the service worked well and in collaboration with all relevant agencies to help ensure there was joined-up care provision. There was a duty of candour policy in place which was followed and understood by the manager and the provider's representative who were also aware of their responsibilities and notified CQC of significant events and safeguarding concerns. This meant that they were aware of and had complied with the legal obligations attached to their role.

The provider had displayed their previous rating and link to the full report on their website. The ratings were not displayed in the agency's registered office; however, we were told this was displayed in the secondary office which was where staff and visitors were more likely to attend.

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 registered person has failed to ensure that all risks relating to the provision of care have been assessed and kept under review. Regulation 12 (1)(2)(a)