UK Top Care Limited

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Inspection report

Unit D3, 111 Ross Walk
Leicester Business Centre
Leicester
Leicestershire
LE4 5HH

Tel: 01162330092

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
UK Top Care Ltd is a domiciliary care agency providing personal care and support to people in their own homes. 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. At the time of our inspection there were 6 adults who received packages of support which included personal care.Systems to assess, monitor and improve the quality of the service were not always effective. This included oversight of people's care records, staff training and competency. Quality assurance checks took place in some of these areas but these were not consistent they did not identify the issues we found during this inspection.

There was a continued lack of effective leadership. The provider's business continuity plan did not include management contingency plans in the event the registered manager was absent. We found the service was managed by the administrative staff member with limited relevant management experience and knowledge of working in social care whilst the registered manager was on holiday.

Staff had not received induction and essential training in all key areas of care provision to help ensure they had the skills and knowledge to fulfil their roles. There was no system to support and supervise staff and to ensure staff were kept up to date about changes to people's needs or practices. Whilst we found no evidence people

People's experience of using this service and what we found
were harmed, they remained at risk because staff were not trained.

People and relatives told us they felt safe with the staff and the care provided. The provider understood their role to act on abuse and report it to relevant external agencies but further action was needed to ensure all staff were trained in this area.

Risks to people's safety were assessed and measures were put in place to reduce any risks.
People were supported with medicines administration and care plans detailed the level of support when this was required. Further action was needed to ensure all staff were trained to support people with medicines.

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; and policies were in place to support this practice. We have made a recommendation about the principles of the Mental Capacity Act.

There were sufficient numbers of staff who had been safely recruited to meet people's needs.

People and relatives told us staff always used PPE to protect them from risk of infectious diseases. Systems

were in place to control and prevent the spread of infection.

Rating at last inspection and update
The last rating for this service was requires improvement (published 11 December 2019). 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 found the provider remained in breach of regulations.

Why we inspected
We carried out an announced focused inspection of this service from 6 to 14 November 2019. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and governance. This inspection was in part prompted by a review of the information we held about this service.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions safe and well-led which contain those requirements.

We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this report.

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

Enforcement and Recommendations
We have identified continued breaches in relation to staffing and governance oversight systems at this inspection. We issued 2 warning notices, which required the provider must make improvements to meet the regulations.

This report only covers our findings in relation to the Key Questions; Safe and Well-led which contain those requirements. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor the provider's progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

UK Top Care Ltd

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 1 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because it is a domiciliary care agency and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 22 February 2023 and ended on 6 March 2023. We visited the location's office on 22 and 23 February 2023 and 6 March 2023.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. This included the provider's action plan which set out their plans to meet the regulations. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used information gathered as part of the monitoring activity that took place on 15 June 2022. We sought feedback from the local authority who work with the service. We used all this information to plan our inspection and inform our judgements.

During the inspection
We spoke with 2 people and 2 relatives about their experience of the care and support provided. We spoke with 5 staff and they included the registered manager, administrative staff, and care staff. The administrative staff member facilitated the inspection on 22 and 23 February 2023. The registered manager facilitated the inspection on 6 March 2023. We also received an email with feedback from another care staff. We looked at aspects of care records for 4 people and 3 staff files in relation to recruitment. We reviewed a range of documentation relating to the management of the service including quality audits and policies and procedures.

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. At this inspection the rating 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.

Staffing and recruitment

● People's safety was at risk because staff had not received the essential training for their role. This included topics related to health and safety, support with medicines, safeguarding adults and manual handling. People who required the use of equipment for their safety and movement were supported by staff not trained in moving and handling. Staff did not know how to deal with unforeseen emergencies such as a fall. This put people at risk of further harm from untrained staff.

● The provider did not provide induction training to all staff or check their practice before they supported people. For example, one staff member with no experience of working in social care had supported a person for 5 months without completing induction training. The induction training was booked for 1 March 2023. The lack of essential training for staff put people's safety at risk.

● The registered manager told us some staff practices in the safe moving and handling of people had been assessed by a community nurse, but no record was found to confirm this. This meant put people at risk of receiving unsafe care from untrained staff.

The provider had failed to protect people from the risk of harm because staff were not trained, qualified or competent in their role to provide care and support. This was a breach of regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection visit the provider took action. All staff completed moving and handling training to reduce risks to people where equipment was used in the delivery of care. Further action was needed to ensure staff practices were checked. The provider assured us this would be addressed.

● People told us they were supported by regular, reliable staff. One person told us, "I have the same female carer and if she's on holiday, they will let me know who will be coming." A relative said, "[Name] has regular carers; they are always punctual. There's only been once or twice the carers have been delayed and they've called me to say they're on their way."

● Staff were recruited safely. This included obtaining references and checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and help prevent unsuitable people from working in care services.

Using medicines safely

At the last inspection the provider did not have an effective system in place for 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 enough improvements had been made and the provider was no longer in breach of regulation 12. However the action was needed to maintain people's safety.

● Staff who supported some people with their medicines were not always trained to do so. We found people were not harm but action was needed. We have already written about this in the above section under 'staffing'.
● A relative told us staff were required to prompt their family member to take their medicines when they were not at home. The relative confirmed they checked their family member had taken their medicines. The care plan did not reflect this arrangement. We found no evidence of harm to the person. We discussed this with the registered manager and they assured us they would review the person's care plan to ensure it reflected the support they required with medicines.
● Where people were prescribed topical creams to be applied to prevent skin damage, this was recorded in their care plans. One person confirmed staff followed the care plan and applied the topical creams where required to prevent skin damage.

Assessing risk, safety monitoring and management
● Risks associated with people's care, support and the home environment had been assessed and care plans provided guidance to enable staff to support people safely. Staff we spoke with understood how to support people and followed the guidance in the care plan. Staff gave examples of how they managed known risks such as falling by ensuring there were no obstructions or risk of trip hazards.
● People told us staff supported them safely. One person said, "My carer seems confident, knows how to support me, listens to me and takes steps to make sure there's no risk of me falling." A relative said, "I've observed staff do transfers; they do move and transfer [Name] safely otherwise I will say if [Name's] not safe."

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 make particular decisions, any decisions 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 MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

● People told us staff always sought consent before they were supported. People's capacity to make decisions was considered. Records showed people were supported by family members to make more complex decisions.
● There was a MCA policy and procedure in place, however, the registered manager was not fully aware of the process for best interest decisions when a person lacked capacity or had fluctuating capacity. We have written about this in the well-led section of this report.

We recommend the provider fully understands the procedures to comply with the MCA principles where people lack capacity.

Systems and processes to safeguard people from the risk of abuse
● People and relatives we spoke with said they felt comfortable, safe with the staff and the care provided.

One person told us, "My carer is very good, she's kind to me and makes me feel safe."
● The provider had a safeguarding policy and knew how to follow local safeguarding processes when required. The registered manager was aware of their responsibility to liaise and report to the local authority and CQC if safeguarding concerns were raised.

Learning lessons when things go wrong
● The provider did not have a system to record all incidents and accidents such as falls. Staff were not able to tell us if lessons were learnt as staff meetings were not consistent or reliable. We have written about this further in the well-led section of this report.

Preventing and controlling infection
● People's safety was promoted through the prevention and control of infection. The provider ensured personal protective equipment (PPE), such as disposable aprons and gloves were available and used by staff when supporting people with personal care.
● People told us staff wore PPE when carrying out tasks.
● Staff confirmed they had a good supply of PPE and disposed of them after each task. Records showed some staff practices had been checked by the registered manager during the spot checks to ensure infection control procedures were followed.

Requires Improvement

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. At this inspection the rating has changed to 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 our last inspection the provider did not have an effective system in place to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, not enough improvement had been made and further action was still needed. Therefore, this was a continued breach of Regulation 17.

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

- At the last inspection the provider quality assurance audits and checks in some areas of the service were not sufficiently robust to identify issues and take prompt action to remedy. The provider's action plan had not been updated and some issues were still not addressed. At this inspection we found similar issues. This put people at risk of harm.
- There was a continued lack of effective leadership. The service was managed by the administrative staff member with limited relevant management experience and knowledge of working in social care whilst the registered manager was on holiday. There was no additional external managerial support identified. Care staff relied on each other should they require information or support. The provider's business continuity plan did not include management contingency plans. This placed people at increased risk of harm.
- There was ineffective oversight systems to monitor people's care and care records. For example, care plans were not kept up to date to reflect people's current needs, support required and clear guidance for staff to follow to meet those needs. This put people at risk of receiving inappropriate care.
- The provider did not have oversight of staff training and competence. There was no record of the staff skill mix and staff knowledge and competencies were not always checked. This put people at risk of harm.
- There was no system to monitor incidents, accidents, safeguarding concerns and complaints. This meant opportunities to identify any trends so action could be taken were missed.
- There was no system for learning lessons. For example, staff were still not sufficiently trained and the governance systems had not improved. There was no system to share information and to review the quality of service being provided, for example through team meetings. This meant the provider did not have an accurate overview of what was happening in the service.

The provider's oversight systems and processes required further improvements to effectively monitor and mitigate risks to people's safety. The lack of leadership and management oversight of the quality of care

provided increased the risk of harm. This was a continued breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● There was no oversight of feedback gathered about the quality of service. A sample of the surveys we viewed ranged from 2018 to 2022 and were mostly positive. However, these were completed by the registered manager with people and their relatives. No other evidence was found that showed how the provider sought people's views. The lack of systems and frequency to gather feedback meant people could not contribute or influence the service development.

● People's care plans were not kept up to date, and we were not assured that their equality characteristics were always effectively considered

● At the last inspection the provider had not kept up to date with changes in legislation. At this inspection no improvements were found. For example, the registered manager did not fully understand their role to comply with the Mental Capacity Act. They referred to out of date legislation for the regulation of services by the CQC. The lack of awareness of relevant information and how to source relevant information and good practice guidance impacts on the management of the service.

The provider failed to have effective oversight to ensure people received inclusive person-centred care. This was a continued breach of Regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and relatives were confident concerns raised would be taken seriously and resolved. One person told us they liked the care staff because they were able to converse with them in their preferred language which was not English. A relative said, "I've got no complaints, if I did [registered manager] gets a call straight away."

● Staff felt confident to speak with the registered manager if they had any concerns. One staff member said, "Every Monday I go to the office and get feedback from [registered manager] about people and I'm told I'm doing a good job."

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 had not displayed the correct CQC rating awarded at the last inspection. It is a legal requirement for all regulated health and care services to display the CQC rating awarded. When we raised this with the registered manager immediately displayed the correct CQC rating.

● Following our inspection visit the registered manager organised an external trainer to deliver moving and handling training. All care staff, the administrative staff and the registered manager completed this training. This provided some assurances that staff were trained to support people safely when equipment was used in the delivery of care.

● The registered manager was aware of their responsibility to keep people informed in relation to complaints and actions taken following incidents in line with the duty of candour.

Working in partnership with others

● People and relatives told us health and social care professionals were involved in their care. The registered manager told us they had contacted relevant professionals when people's needs changed and when their package of care needed reviewing.

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 provider's oversight systems and processes remained ineffective. The lack of leadership and management oversight of people's care placed increased the risk of harm. There were limited opportunities for people and staff to give feedback on the service. Regulation 17 (1) (2)

The enforcement action we took:

We issued a Warning Notice.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People who use the service were at risk of receiving unsafe care and support because staff were not trained, competent and qualified; nor understood their responsibilities fully and were not supported to provide safe care and support. Regulation 18 (1) (2)

The enforcement action we took:

We issued a Warning Notice.