Universal Care Limited

Universal Care - Beaconsfield

Inspection report

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Date of inspection visit:
06 March 2020
09 March 2020
10 March 2020
13 March 2020
16 March 2020
18 March 2020

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Universal Care – Beaconsfield is registered to provide 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 the inspection the service supported over 200 people.

People's experience of using this service and what we found
People continued to be placed at risk of harm due to a lack of systems to promote safe care and treatment.

Potential risks to people were not routinely and consistently assessed. Staff were not always aware how to promote people's safety. People who required support with medicine administration were not always supported in a safe manner.

The provider and registered manager had failed to act on all previous concerns raised and did not routinely have adequate measures in place to ensure people were protected from potential harm. Quality monitoring systems were either ineffective or not in place. We found repeated and continued breaches of the regulations. Legal requirements as stated in the provider's registration were not routinely complied with. For instance the provider failed to inform us of events it was legally required to do so.

People were not always supported to have maximum choice and control of their lives and staff; the policies and systems in the service did not routinely support this practice. We found staff did not always comply with the Mental Capacity Act 2005.

People's privacy and dignity was not routinely upheld. We were informed personal information had been shared with people who were not legally entitled to received it. We asked the provider to refer themselves to the Information Commissioner Office, following a data protection breach.

People told us they had developed a good relationship with staff comments included "They are lovely, brilliant", "I found them excellent" and" I'm very happy."

People and their relatives told us they knew how to make a complaint and would not hesitate to contact the office.

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 Inadequate (published 1 October 2019) At this inspection enough improvement had not been made/sustained and the provider was still in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

Enforcement
We have identified continued breaches in relation to risk management, record keeping related to medicines and staff training. The provider failed to notify CQC of certain events, to comply with the Mental Capacity Act 2005 and to monitor and improve the quality of the service to people. We have identified a further breach of regulations as the provider failed to notify us of changes to directors of the limited company.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The period for representations and appeals has concluded and we have begun the process for cancelling the provider's registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Universal Care - Beaconsfield

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 team consisted of three inspectors and an assistant 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the registered person short 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.

Inspection activity started on 6 March 2020 and ended on 18 March 2020. We visited the office location on 9, 10 and 16 March 2020. We made telephone calls to people on 6 and 9 March 2020. We visited people on the 10 and 11 March and we followed up on information on 18 March 2020.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with 18 people and or their relatives about their experience of the care provided. We spoke with ten members of staff including the provider, registered manager, managing director and care co-ordinators.

We reviewed a range of records. This included 16 people's care records and multiple medication records. We looked at eight staff files in relation to recruitment and staff supervision. We requested a variety of records relating to the management of the service, including policies and procedures to be sent to us. We took away a number of documents to review in the office. We requested information be sent to us by the provider and received this to review.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We reviewed information sent to us by the provider. We spoke with one professional who regularly supported people and contacted people and their relatives to clarify information.

Inadequate

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 Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our inspection in June 2018 the registered person had failed to assess the risks to the health and safety of service users of receiving the care or treatment. They failed to do all that was reasonably practicable to mitigate any such risks. This was a breach of Regulation12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At our last inspection in August 2019 the provider had continued to put people at risk of avoidable harm. This was a continued breach of Regulation 12.

At this inspection not enough improvement had been made and the provider was still in breach of Regulation 12.

● People were not routinely and consistently protected from potential risks. The provider had failed to identify, assess and do what was reasonably practicable to mitigate risks to people.
● One person had an assessment and support plan dated October 2017, this identified the need for a moving and handling risk assessment. We noted the risk assessment had been written on 10 October 2019. It stated the person could walk unaided and could weight bear and advised they used a walking stick. The risk assessment stated no support was required with the person moving positions (transferring from a seated position to a stand or bed as an example). We noted the person had fallen at home in December 2019 and had been hospitalised. A review of the notes held by the provider in the office demonstrated there had been a marked deterioration in the person's care needs since they had been discharged from hospital. As part of the inspection we visited the person at their home. We found them to be requiring the support from two care workers to move positions. The moving and handling risk assessment had not been updated. In addition, the member of staff told us they had found a transfer aid in the garage that had been issued to the person's late husband. The member of staff told us they had washed it and taken it inside to use to help the person move from their bed to armchair. The daily notes confirmed staff used this on a regular basis. No healthcare professional had assessed it was safe to use this equipment. This placed the person at risk of harm.
● One person had fallen at home in March 2020. We looked at their moving and handling risk assessment. This was undated. It stated the person could walk and the advice for the care staff was to "Walk with [Name of person] with the wheelchair behind her whilst she uses her walking frame." We found the risk assessment contradictory as it also stated the person needed support from two staff to use a hoist in the morning to "Transfer from bed to commode". We looked at the person's support plan and it stated the person needed support from two staff in the morning as "Since September 2019 [Name of person] has a full body hoist". We noted the evening call support plan stated "[Name of person] is able to support herself for the transfer providing the carer is close by and not leave [Name of person] alone. We had concerns about the

contradictions cited in the care plan. We contacted their family member who told us prior to the person falling they were not walking and was unable to stand and transfer to a wheelchair. They told us a hoist was used for all transfer from moving from bed to a wheelchair and then into a reclining armchair. This meant the support plan and risk assessment did not identify accurately how the person should be supported and staff might therefore not know how to support them safely.

● We found other examples of where people's needs had changed and moving, and handling risk assessments had not been updated to reflect the changes.

● We found people who were at risk of pressure damage to their skin and had been supplied with a hospital bed and pressure relieving mattress from the NHS; did not routinely have a risk assessment in place to help manage the risk of skin breakdown. We were informed one person had an open wound on their heel. However, no risk assessment was in place to advise the staff what checks were required to prevent further deterioration. For instance, a check of the pressure mattress would be required.Where hospital bed had been fitted with bed rails and were used, we found the service did not routinely and consistently assess the risk. This meant people could have restrictions placed on their movement unfairly.

● People who were at risk of choking or were at high risk of malnutrition had not been routinely assessed. Staff did not always have readily available and up to date advice on how they should mitigate the risk. One person had a very low appetite and was being encouraged to maintain their hydration and nutritarian. They had a nutrition and hydration assessment dated 10 October 2019 which stated their nutritional value was 'good' and their ability to prepare their own drinks was 'good'. We visited the person and found them to be requiring full staff support with all meals and drinks and was having fortified drinks and had been reviewed by a dietitian. The care plan and risk assessment had not been updated to reflect the change in need. Another person's assessment and support plan stated they had "A soft/blended diet" and was "at low risk of choking". The support plan or choking risk assessment did not refer to the consistency of food or fluid in line with the International Dysphagia Diet Standardisation Initiative (IDDSI). This had the potential to put them at risk of choking if the wrong consistency of food was provided to them.

● The registered manager told us in their completed PIR since the last inspection "Appreciable work has been carried out to improve the situation and this has included the introduction of new revised care plans which are more comprehensive and person-centred… However, the most significant improvement is the attachment of all required risk assessments." We found this was not the case and risks posed to people had not been routinely assessed. For instance, we found risk assessments had not been revised when people had an event like a fall or a hospital admission which changed their needs. One person had fallen three times in December 2019 and no falls risk assessment was in place to reduce the likelihood of another fall.

We found the service had not addressed our previous concerns about the management of risk and systems were not in place to ensure people were protected from potential risks. This was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our inspection in June 2018 the registered person had failed to ensure people were supported with their medicines in a safe way. This was a breach of Regulation12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At our last inspection in August 2019 the provider had continued to fully ensure people were supported safely with their medicines. This was a continued breach of Regulation 12.

At this inspection not enough improvement had been made and the provider was still in breach of Regulation 12.

● People were placed at risk of harm as a result of the unsafe management of medicines. Staff were administering medicines which had not been recorded by the office as needed. Since the last inspection the provider had changed their documentation and had introduced a new medicine form. The registered manager told us in their completed PIR "Appreciable work has been carried out to improve the situation and this has included the introduction of new revised care plans which are more comprehensive and person-centred, with the addition of a new medication record form." The provider had two documents which staff needed to follow. The "medication record form" which followed national guidance (NICE NG67: Managing medicines for adults receiving social care in the community). In addition, the staff had a "medicine chart". The provider's expectations on the staff were noted in a "medication policy" dated 25 July 2019. It stated staff should "Make a note on the client's Medication Chart (which is kept in the client's Care Book) of all medication they have administered. The record must include the date, time, name of the medication (including creams, ointments and patches) and dosage given. The carer must sign against every entry they make on the Medication Chart." We found people's records did not always contain the new record form and therefore did not follow NG67 guidance. This meant staff did not routinely have access to full information on what the medicine was and how it should be administered.
● We found people's "Medication record" did not routinely and accurately reflect what medicine people needed staff to support them with. One person's record stated "[Name of person] doesn't take any medication." However, we noted the care staff had written in the daily observation notes on more than one occasion they had "Meds given". A staff meeting had taken place on 28 February 2020 where staff had been advised of this person's new medicine. However, the medicine record had not been updated to reflect this. We found when care staff administered medicine from a pharmacy pre-filled multi- medicine packet they recorded they had given "Dossett box". There was not always a record of which medicines had been given. This was against best practice guidance and the provider's own policy. We found incomplete medicine administration records increased the risk of medicine errors occurring.
● Another person's medicines record stated they were prescribed two medicine each one to be given once a day. We visited the person at home and found staff had administered more medicine than the ones cited on the medicine record. Records viewed from the 20 January 2020 showed pain relief and antibiotics had been routinely been given. In addition, we noted from 5 March 2020 the person was administered a morphine-based medicine. The person's medicine record had not been updated to reflect the newly prescribed medicines.
● We noted people were prescribed medicines for occasional use (PRN). The providers "Medication policy" stated "PRN medication is administered as and when required. It is at the discretion of the client as to when they feel that this medication is needed. The medication instructions should include a dose to be taken and also a maximum frequency. These instructions should be followed, and the carer should record all PRN medication taken in the client's Medication Chart with details of the date, time, dosage and name of the medication." We found the provider did not routinely record PRN medicines on people's "medicine record" or "medication chart" and we found the maximum dose was not always recorded. On one person's file we found a medicine had been given too frequently as the stated four-hour period had not lapsed in between doses. This had the potential to cause harm to them as a result of being overdosed.

At this inspection not enough improvement had been made. We found systems were either not in place or robust enough to ensure the proper and safe management of medicines. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

At our last inspection in August 2019 the provider had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the

experience of service users in receiving those services). The provider failed to evaluate and improve their practice in respect of the monitoring they had completed to drive forward improvements. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found not enough improvement had been made. The provider had not ensured lessons were learnt when care was not delivered as planned or when accidents or near misses occurred. This was because system where either not in place or ineffective to improve the quality of safety of services provided. At this inspection not enough improvement had been made and the provider was still in breach of Regulation 17.

● People who had fallen or had suffered injuries were not protected from a future re-occurrence. The provider's policies and procedure were not robust enough to ensure all accidents, near misses were recorded and or investigated.
● One person had fallen in December 2019 and had suffered a deep cut to their leg. We asked to see the records relating to the incident. The registered manager could not locate any incident form. Another person had been admitted to hospital in March 2020. We asked the registered manager to show us any incident form completed. They could not locate one. We asked the registered manager if they expected staff to complete an incident form n such circumstances and they told us they did. On day one of the inspection we asked to see the policy which provided guidance for this. We followed this up with a written requested on 10 March 2020. On 13 March 2020 the registered manager sent us a document titled "Accident or Incident Reporting Policy", the documents had no issue date but a review date of October 2020. We discussed this document with the registered manager on the 16 March 2020 and they told us it has been written following our request to see any guidance for staff on what should be recorded in the event of an accident.
● On 16 March we asked the registered manager if any prior documents existed to guide staff on what they should do in the event of an accident or incident. The registered manager handed us a document titled "General statement of policy on health and safety", this was dated 30 September 2019. The document stated "The accident record book in the secretary's office. [Name of senior member of staff] is responsible for recording accidents in the book".
● On 9 March 2020 We asked the registered manager if any accidents had been recorded. They told us "I think we should be able to see some accident forms, but I think you have already identified a hole in our system." Later the same day the registered manager told us "Here is an example that we are now completing accident form, I fully accept we had not met that" The registered manager had handed us a copy of an incident report form completed on 9 March 2020. The incident had occurred on 06 March 2020. The registered manager confirmed action would be taken to improve incident recording.
● People were placed at risk of harm as accidents were not routinely recorded. This meant there was a lack of learning to prevent a future similar event.

We found systems were either not in place or effective to ensure learning from events was embedded into the service.The registered manager did not have effective systems in place to ensure staff took appropriate action when an accident did occur. This placed people at continued risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

At our last inspection in August 2019 the provider had failed to ensure people were protected from the risk of abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment,)

of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 13.

● Since the last inspection the provider has updated their safeguarding policy. We have discussed possible further changes the provider could make to ensure terminology within the policy reflects The Care Act 2014. Staff had been trained in the topic of safeguarding adults at risk. Staff who provided feedback to us were knowledgeable about what they would report and told us they would not hesitate to contact the office. Comments included, "I attended safeguarding training a few months ago and updated my knowledge", "I would report any incident which was detrimental to the client," "I learn how to record and report abuse and neglect appropriately. If abuse is suspected then everything needs to be documented, factual, legible, signed and dated" and "Safeguarding training helped me to understand which clients are at risk of harm or are particularly vulnerable, signs of abuse and neglect."
● Since the last inspection the provider had reported allegations of abuse to the local authority and have worked alongside them to help investigate concerns raised.

Staffing and recruitment

At our inspection in June 2018 the registered person had failed to establish and maintain an effective staff recruitment procedure. The registered person had failed to ensure applicants were of good character and that information specified in Schedule 3 was available for each staff member. This was a breach of Regulation 19 (Fit and proper persons employed) and Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the last inspection in August 2019 we found not enough improvement had been made and the registered person was still in breach of Regulation 19 and Schedule 3.

At this inspection we found enough improvement had been made and the registered person was no longer in breach of Regulation 19 and Schedule 3.

● People were supported by staff who had been through safe recruitment processes. Recruitment records viewed showed the service had carried out all the required pre-employment checks for new staff. This included an employment history, references and Disclosure and Barring Service checks (DBS). A DBS is a criminal record check.
● The provider had introduced a checklist which required to be signed by one of the senior management team prior to a new member of staff being passed for working alone with people.
● People told us since the last inspection they had experienced more consistency and continuity in the staff who supported them. The provider used an electronic rostering system to plan workload for staff. Care co-ordinators told us the system had a default setting which meant they could roster workloads in advance. The registered manager confirmed they were committed to limiting the number of care workers a person would have to ensure continuity. Feedback from people confirmed in the main this occurred. Comments included "They've improved since the last inspection… I have three regular girls and occasionally another girl. They know where everything is." Another person told us they had a consistent group of carers.
● We received mixed feedback about the care visits being made on time. Some people told us they had "Consistent care workers, no missed visits, no experience of them running late" and "There haven't been any late or missed visits." Other people told us they had experienced missed calls. One relative told us they had been asked to cover calls when care staff were not available. Another relative told us care visits not planned at the times we requested, care folder not updated accurately, updated care plan not placed in client's care folder. We discussed missed calls with the registered manager, and they told us the number of missed calls

was relatively low. We have asked they continue to report missed calls to the local authority. We provided feedback to the registered manager after the site visit to ensure all communication about missed calls, late calls and any action taken was recorded.

Preventing and controlling infection

● People were protected from the risk of harmful infections.

● Staff had received training in the prevention of infections. Staff had access to personal protective equipment (PPE) such as gloves and aprons.

● People and their relatives gave us positive feedback about how staff ensure properties are kept clean. Comments included "They also leave the place (kitchen and bathroom) spotless" and "They clean up after themselves."

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance

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.

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.

We checked whether the service was working within the principles of the MCA

At our inspection in June 2018 the registered person had failed to ensure staff were competent and following the law in relation to the Mental Capacity Act 2005 Code of Practice. This was also a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the last inspection in August 2019 we found not enough improvement had been made and the registered person was still in breach of Regulation 11.

At this inspection we found some improvements had been made, but the registered person remained in breach of Regulation 11. This was because some documentation pertaining to consent and mental capacity assessments was incorrectly completed.

- Although staff had received training in the principles and practice associated with the MCA, it was sometimes incorrectly interpreted and applied to people's support plan documentation and consent seeking processes.
- Mental capacity assessments are only completed where there is a potential or actual impairment of a person's brain or mind. However, capacity assessments were completed for all people who used the service and were stored in their care documentation. This went against the MCA principle which states people's capacity to consent must always be presumed, unless otherwise proven.
- Some mental capacity assessments contained contradictory information. For example, in the assessment

form it stated the person did not have capacity and, in another part, it stated the person did have capacity to consent to the care and support received. This meant there was a potential for staff to support them in the wrong way and may not have been in their best interest.
● Where a person was deemed incapable of consenting and did not have a registered lasting power of attorney held by the Office of the Public Guardian, best interest decision making was recorded. However, in each example we viewed, none of the forms documented what practicable steps had been taken to assist the person attempt to make a decision. A 'checklist' style document was used, which contained no place for recording how the decision was made in the person's best interest.
● There were no records of why an independent mental capacity advocate may be required, nor was there records of an advocate being consulted when legally required during decision making.
● There were no records to indicate that a person's capacity may be fluctuating (that is, they were unable to consent to a decision at a particular time but were able to at other times). Mental capacity assessments were not reviewed frequently enough to reflect any changes in a person's ability to provide valid legal consent.
● Where a person did not have capacity to consent, the service had checked whether there was an attorney appointed under a valid enduing lasting power of attorney. As needed, a copy of the document registered with the Office of the Public Guardian was obtained and placed on file.
● Care documentation showed that some people, or others legally able to provide consent on their behalf, had signed agreements to care and support and to other matters such as sharing of personal data.

This was a continued breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff support: induction, training, skills and experience

At our inspection in June 2018 the registered person had failed to ensure staff received appropriate training and supervision as was necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the last inspection in August 2019 we found not enough improvement had been made in relation to staff training and the registered person was still in breach of Regulation 18.

At this inspection we found some improvements had been made, but the registered person remained in breach of Regulation 18. This was because risks to people were not always mitigated because of continued gaps in training.

● People were not routinely supported by staff who had received adequate training to ensure they received safe care. This placed them at continued risk of harm. At the last inspection we had concerns that people who received nutrition, fluids and medicine via a percutaneous endoscopic gastrostomy (PEG) were supported by staff who had received no training. The provider told us in the PIR "All potential carers are required to undergo 4 days of induction training and subsequently undergo shadowing in accordance with our shadowing policy. All staff are required to undertake mandatory training every 18 months. Mandatory training is considered to be manual handling, safeguarding and medication. Regular opportunities are provided for staff to attend specialist training covering subjects such as Parkinson's, Multiple Sclerosis, Falls Prevention, Epilepsy and PEG feeding."
● We examined the staff training records for those who supported people with a PEG, we found all staff who supported the people had not always received PEG feed training prior to supporting them. This was contradictory to what the provider had told us. The lack of training continued to place people at risk.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate people were sufficiently protected from avoidable harm. This placed people at risk of harm. This was a continued breach of regulation 18 Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Since the last inspection the provider had improved support for staff and some training opportunities. We found systems were in place to monitor new staff induction. Care co-ordinatiors advised us they kept their own records relating to when staff training was required. We discussed this with the managing director, and they advised us it was hoped in the future the electronic system would generate this. At the time of the inspection an alert was available for some supervisory staff on when their supervisee required a quality check on their performance or a one to one meeting. We were informed this alert relied on the line manager entering dates into the system. Which we found was not routinely carried out.
● Staff who gave us feedback told us they felt supported. Comments included, "I am supported in my role I got all the support I need from Universal Care, my manager", "I am supported in my role. I get all the support I need from my manager, usually I ring if I need any help" and "Anytime I can email or phone my manager. After office times we have Emergency contact number if we need advice or help, even at night. Response is always quick and very supportive."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's likes, dislikes and preferences were now recorded and used in their support. This information was captured in a 'pen portrait' style, printed out and placed in people's care folders in their house and in the office.
● Information was gained from people and their family and additionally recorded in the electronic care system. For people who had difficulty communicating their preferences, observation of their likes and dislikes by staff was reported as the best way to understand their choices.
● People's food, clothing and personal hygiene preferences were documented.
● Cultural preferences and faith-based requirements were recorded and respected by staff. Staff had received training in equality and diversity to help them understand social networks and ways of working with people who maintained different views.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support; Supporting people to eat and drink enough to maintain a balanced diet
● Where people required support with meeting their nutritional and hydration needs this was referenced in their support plans.
● There was evidence the service had joined-up working with health and social care professionals to enable continuity of care for people.
● There was partnership working with commissioning teams, social workers and healthcare professionals. This enabled satisfactory outcomes for people people's health. Where needed, there was the involvement of specialist workers, such as district nurses.
● Evidence of other health and social care staff's involvement in people's care was appropriately documented in people's daily notes and electronic care records by the care workers and care coordinators. This ensured that information was available to support people in the best way possible and could be reviewed if needed.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; respecting equality and diversity

At the last inspection we made a repeated recommendation from the previous inspection regarding the service's ability to demonstrate the requirements of the Equality Act 2010, in relation to people who use the service.

At this inspection we found the provider had failed to ensure people's privacy and dignity were routinely upheld. We found the provider was in breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People's privacy and dignity were not routinely upheld.
- We were informed of a data protection breach. We discussed this with the registered manager. They informed us they were unaware of the situation. However, we received confirmation the issue had been reported to the service. We asked the registered manager to ensure action was taken to ensure they complied with current legislation regarding the protection of people's personal information.
- We found the provider did not routinely ensure unauthorised personnel visited people in their own homes. A complaint had been made to the provider that a member of staff who was not due to work had entered the home of a person without their permission and knowledge.
- We were made aware of a situation when a person at risk due to their limited mobility and health conditions was placed at potential harm as their door had been left unlocked by the staff following their visit. This placed the person at risk of harm.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate that people's privacy was maintained. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Feedback from people demonstrated staff promoted people's dignity when they were supported. Comments included 'They're respectful. They almost treat her like family", "Very caring", "Some are absolutely brilliant", "They are kind" and "They're all good."

Ensuring people are well treated

- People told us they had developed a good relationship with the staff who provided them with support. Comments included "I think on the whole they've been very good", "I have a good relationship with the

carers".

● People told us staff were kind and caring. Comments included, "Very, very caring and efficient carer", "The two we have were extremely kind and caring. Both of them in their different ways are extremely good and very good for my wife", "They are lovely, brilliant", "I would say the standard of care that we have is excellent", "I love the girls, they're like family. We have a laugh" and "Yes, everyone that we have had has been delightful."

● People were not aware of the potential risks posed to them as a result of the lack of effective systems in place to ensure their current needs were met.

Supporting people to express their views and be involved in making decisions about their care

● People and their relatives told us they had been involved in discussion about their care. Comments included, "Was involved in the care plan", "Involved in the care plan" and "We've had one review. If there was any need for change, I would communicate to the carer in the first instance and then to the office."

● People were visited by office staff to review their care needs. The registered manager advised in the PIR "Every 2 years we commission a survey from a market research company who ask both clients and carers their opinion of many aspects of the service which we give to our clients and the assistance and support which we give to our carers. The last survey took place in June 2019 and many valuable statistics were provided by the survey."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

At our last inspection in August 2019 the provider failed to ensure the care and treatment of service users was appropriate, met their needs and reflected their preferences. We found there was a lack of personalised end of life planning.This was a breach of Regulation 9 (Person centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found some improvements had been made, the provider had met with the requirements of Regulation 9. However, we found ongoing concerns. People's current needs were not routinely and consistently recorded. This was a continued breach of Regulation 17(Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider supplied us details of people's care plans which had been reviewed since our last inspection. However, we found no system was in place to ensure reviews of people's care plans occurred when their needs changed. This was supported by what the provider told us in the PIR "Clients' care plans will continue to be reviewed on an annual basis."
● We found examples where people's needs had changed and their care needs assessment, or care plan had not been updated. We found risk assessments had not been updated when required and support plans did not always state how many staff were required to support them safely. This placed them at risk of receiving inadequate or inappropriate care.
● Where office staff visited people they failed to ensure this was used as an opportunity to ensure their current care needs were reflected in their written records. One person had been visited on 14 February 2020. A member of staff had written an end of life care plan with them. However, their risk assessment for moving, and support plan did not reflect their needs.
We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate that person-centred care was effectively managed. This placed people at risk of receiving care which may not be appropriate to meet their needs or reflect their preferences. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and their relatives told us they had received opportunities to update their care needs. Comments included, "It is a senior member of Universal Care, one that specialises in Care Plans." "I can remember it being reviewed three times, but I can't remember the spacing of them."
● People and their relatives told us they were supported to engage in meaningful activities. One relative told

us "They take [Name of person] out, which has been a godsend, a massive bonus for us, they take him out for a walk, and they take him to places to see and do things. It is always their idea, they have maintained the lifestyle he had before, which is fantastic, they are proactive, they don't just come and look after [Name of person], they give him a life."

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

At our last inspection in August 2019 we made a continued recommendation from our previous inspection for the provider to review its operation in relation to the AIS.

● We found people's communication needs had been referenced in their care plans.
● People and their relatives told us their communication needs were met. Comments included, "With thumbs up or thumbs down or shakes his hands to show he's not sure and they understand him, and they are very patient with him."

Improving care quality in response to complaints or concerns
● The service had a complaint procedure dated 30 September 2019. Since the last inspection four complaints have been recorded. The records we observed showed that all had been resolved.
● People and their relatives told us they knew who to speak to about any concerns and would not hesitate to make contact with the provider. Comments included, "I would definitely tell them straight away, but I haven't had cause to, if there was something, I didn't like I would say", "I would email them", "There is a procedure, which is in my folder, but I have never had to complain so I've never followed it. If I have to, I have always been able to talk to someone at Universal Care, but it is not a complaint" and "I would just ring the office. Yes, I would feel comfortable doing that."

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 the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection in August 2019 the provider had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). The provider failed to evaluate and improve their practice in respect of the monitoring they had completed to drive forward improvements. This was a continued breach of Regulation 17 (Good Governance) 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

● People were not routinely and consistently protected from risks and avoidable harm. This was because the provider did not have effective systems in place to monitor whether people's care plans were updated when changes occurred in their care needs so that prompt action could be taken to ensure staff had up to date information about how to support them.
●The provider had not identified the shortfall in their risk reviewing systems we found prior to our inspection. The provider told us in the PIR "There are many procedures in place which would highlight any deficiencies in the standard of care which is being provided. These include the regular review of clients' care plans and risk assessments, spot checks and those supervision visits which take place in clients' homes. Universal Care is a relatively small organisation and the Directors have regular involvement with many clients and regularly visit a number of them. The governance of the service has improved significantly with increased oversight and monitoring of newly implemented systems to ensure they work effectively." We found the systems in place described were not efficient and had been completed as one off exercise rather than responding to people's change in need.
● The provider failed to act on previous concerns raised and failed to ensure systems were implemented to rectify issues found.
● The provider failed to comply with the regulations and the legal requirements as stated in their registration requirements. We found the provider's action plan and internal monitoring following our last inspection; had not been effective to ensure sufficient improvement would be made to meet the regulations in relation to safe care and treatment, consent, good governance, staff training and notification to us. This is

the second consecutive time the service has been rated inadequate overall, the provider's action plan had failed to improve the rating of the service.
● It is the responsibility of the registered provider to operate systems that prevent the breaches of regulation. Where and when these systems exist, and are effectively operated, the risks to people's care are identified and addressed. This ensures service users receive good quality care and are kept safe from harm. However, people were continued to be placed at risk of harm due to the failure of the registered manager and provider to have effective systems and processes in place to prevent harm.

We found people were placed at continued risk of harm as effective governance arrangements were not in place. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found the provider failed to inform us of all reportable events. This was a breach of regulation 18 (Notification of Other Incidents) of the Care Quality Commission (Registration) Regulations 2009.

At this inspection we found some improvements had been made However, not all reportable events were notified to us. We found this to be a continued breach of Regulation 18 (Notifications of other incidents) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had not routinely ensured all events which were legally required to be notified to us where made. One person had fallen and sustained a deep cut (serious injury) in December 2019. Another person had a pressure ulcer which had not been reported to us. A third person had called the police regarding an incident involving their live-in care worker. These were all reportable events. We had not been notified of any of these concerns. We ask provider's to notify us of these important events so we can monitor how they respond to keep people safe.
● Providers are required to notify us when any changes of officers or directors of a registered provider. We noted there had been changes to the provider's directors in the past. We had not received any statutory notifications about this.

We found the provider failed to ensure all reportable events were notified to us. This was a continued breach of Regulation 18 (Notification of Other Incidents) and a new breach of Regulation 15 (Notice of changes) of the Care Quality Commission (Registration) Regulations 2009.

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
● Providers are required to comply with the duty of candour (DOC) statutory requirement. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to registered persons when they are carrying on a regulated activity.
● We asked the registered manager if they had any event which met the duty of candour threshold. They told us they had been "open and transparent" to their staff regarding our previous concerns and potential action.
●The registered manager advised in the PIR, they had five safety incidents which had triggered the threshold for DOC. On the 18 March 2020 we asked the registered manager to share with us the information regarding

the incident and their compliance with Regulation 20. The registered manager told us " You are correct that we did not follow some detailed aspects of our Duty of Candour policy." However, further commented " But I can confirm that at all times we met the requirements of Regulation 20."

We recommend the provider seek guidance from a reputable source to ensure the duty of candour requirements are fully understood by all staff.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- The provider informed us in their PIR "Universal Care was a founder member of the United Kingdom Homecare Association and remains a member using many of their resources. One of the Directors is a Fellow of the Institute of Directors and as such is able to access advice in relation to many areas of business including Employment Law. Universal Care is a member of the Berkshire Care Association and a member of our office staff has recently attended a Seminar which they held. We have already mentioned our objective of having all of our staff and carers recognised as Dementia Friends. We are members of the Living Wage Foundation and meet their requirements in relation to all of our staff."
- The provider told us they had forged links with local end of life care providers. The provider routinely supported local charities and fund raised for local and national charities. In addition, they had also forged links with the Alzheimer's society to support with training for staff to become dementia friends.
- The provider offered trainee police officer's a placement to provide them an opportunity to engage with people living with dementia. Since the last inspection the provider had worked with the local authority on improvements and had continued to be supported by them.

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 15 Registration Regulations 2009 Notifications – notices of change How the regulation was not being met The provider failed to ensure they notified us when changes occurred.

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 18 Registration Regulations 2009 Notifications of other incidents How the regulation was not being met The provider failed to ensure it notified us of events it was legally responsible to inform us.

The enforcement action we took:

We issued a notice to cancel the provider's registration

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect How the regulation was not being met The provider failed to ensure people's privacy was routinely upheld.

The enforcement action we took:

We issued a notice to cancel the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent How the regulation was not being met The provider failed to ensure it compiled with the Mental Capacity Act 2005.

The enforcement action we took:

We issued a notice to cancel the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met The provider failed to ensure it compiled with the

Mental Capacity Act 2005.

The enforcement action we took:

We issued a notice to cancel the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met The provider failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). The provider failed to evaluate and improve their practice in respect of the monitoring they had completed to drive forward improvements.

The enforcement action we took:

We issued a notice to cancel the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met The provider had failed to provide such appropriate support, training, professional development, supervision and appraisal as is necessary to enable staff to carry out the duties they are employed to perform.

The enforcement action we took:

We issued a notice to cancel the provider's registration.