Universal Care Limited

Universal Care - Beaconsfield

Inspection report

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

Summary of findings

Overall summary

About the service
Universal Care Beaconsfield provides care in people's own homes. It provides a service to older adults and young disabled adults. Approximately 200 people were receiving care at the time of our inspection.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
People told us they felt safe using the service and spoke positively about the support they received. People felt their privacy, dignity and independence were respected. They expressed a high level of satisfaction in a recent independent survey and would recommend the service to others.

People who used the service and staff described a positive culture at the service. Staff said there was good teamwork and an inclusive workplace. They told us they would feel confident in raising any concerns with managers.

The service was responsive to people's changing needs. We saw examples where people had been referred to other agencies so their needs could be re-assessed. There was also liaison with family members. People's complaints were investigated by the service and responded to promptly and an apology given.

We found the service had not always taken appropriate measures to protect people from the risk of avoidable harm. People's care plans did not always contain guidance care workers needed to support people with their health conditions. This placed people at risk of ineffective and unsafe care. There were also no end of life care plans, to make sure people's needs and wishes were recorded.

Where people were supported with their medicines, we found records had not been always been maintained to an acceptable standard. The service had not ensured care workers had been properly assessed and observed before they were permitted to handle people's medicines, to ensure this was done safely.

Staff had received training on safeguarding people from abuse. People we spoke with and staff we contacted did not express any concerns. We found some instances where the service had not made referral to the local authority, to report safeguarding incidents. This meant the service was not always following proper procedures to protect people and alerting statutory agencies.

Robust recruitment practice was not always followed. A care worker had been allowed to start on a basic level Disclosure and Barring Service (DBS) check, rather than enhanced level. This checks for criminal convictions and inclusion on lists of people unsuitable to work with vulnerable people. There was no risk

assessment, supervision or checks of the care worker until their enhanced DBS check was completed. This potentially placed people the care worker supported at risk of harm.

Staff said they felt supported. They said there were back-up systems for them to contact a manager or senior if they needed advice. New workers completed an induction which included training the provider considered mandatory. However, care workers were not observed and assessed in the workplace to ensure they provided appropriate levels of support. We found patterns of supervision varied. Some new care workers had not received supervision or other support until after three or five months of working. We did not see any evidence of appraisals being undertaken to discuss staff performance and their developmental needs.

Care was not being provided in line with the Mental Capacity Act (2005). The service had not always obtained verification of Lasting Power of Attorney documents, so it could be assured of consulting people who had legal authority to act on others' behalf. There were also no records of the service holding best interest meetings where people lacked capacity. Therefore we could not be certain people were supported to have maximum choice and control of their lives and were supported by staff in the least restrictive way possible and in their best interests.

The service had developed policies but these were not always fit for their intended purpose. Recommendations have been made about the service's policies on the Equality Act 2010 and the Accessible Information Standard.

Leadership and monitoring of the service were not effective in ensuring people received good quality care which kept up to date with legislation and best practice. The registered manager had not demonstrated an understanding of their responsibilities in meeting the regulations. We found there had not been satisfactory progress in meeting the breaches from the last inspection. We had also not been informed of all events which providers and registered managers are required to notify us about.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (report published 7 August 2018) and there were multiple breaches of the regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

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

Why we inspected
This was a planned inspection based on the previous rating.

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

Enforcement
We have identified continued breaches at this inspection in relation to staff recruitment practice, staff support, monitoring of the service, consent to care, mitigating risks to prevent avoidable harm, ensuring people received appropriate care and support to meet their needs. We have identified a further breach in relation to notification of significant events.

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.

The overall rating for this service is 'Inadequate' and the service is therefore 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 six 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 of 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

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 was carried out by one inspector. An Expert by Experience contacted people who used the service and relatives by telephone. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes. 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
This inspection was announced. We gave the service 48 hours' notice of the inspection. This was because we needed to make sure someone would be available to facilitate the inspection process and provide access to records.

Inspection activity started on 12 August 2019 and ended on 23 August 2019. We visited the office location on 21 and 22 August 2019.

What we did before the inspection
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 reviewed information we had received about the service since the last inspection. We sought feedback from nine community professionals who work with the service. We contacted 40 staff by email and invited them to provide feedback to us. We used all of this information to plan our inspection.

During the inspection
We spoke with the registered manager and other staff which included a care supervisor, care manager, dementia care adviser, recruitment manager and the managing director of the service. We spoke with five people who use the service and 15 relatives on the telephone.

We looked at a range of records. These included ten people's care plans, eight staff recruitment and development files and a sample of staff and office meeting minutes. We sampled medicines administration records and audits of these. Other records included a sample of policies and procedures and the results of a recent independent user satisfaction survey.

After the inspection
We sought clarification from the registered manager regarding specialist training.

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 requires improvement. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to ensure people were protected from the risk of avoidable harm. This was a breach of regulation 12 (Safe Care and Treatment) 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 12.

• People were not always kept safe to reduce the likelihood of avoidable injury or harm.
• Risk assessments had not been written for all known risks. For example, one person's assessment by their funding authority said they suffered from sleep apnoea. This is a potentially serious condition where breathing repeatedly stops and starts when the person is asleep. There was no risk assessment for this, to ensure the person was kept safe.
• In one file, we saw the person had a percutaneous endoscopic gastrostomy (PEG). This is where a tube is passed into the stomach through the abdominal wall, most commonly to provide nutrition. Records showed they could also take a limited amount of soft food by mouth. There was no risk assessment for managing the PEG.
• The service's risk assessment for supporting the person with their diet mentioned the soft diet and referred care workers to take instruction from a family member. There was no specific assessment to reduce the high risk of choking or to advise staff on what to do if the person started to choke.
• In another file, we saw the person was at high risk of developing pressure wounds. Their risk assessment for this said they did not always co-operate with care workers regarding pad changes to manage incontinence and personal hygiene. The risk assessment went on to say the person had a history of "lashing out at carers." It said "Carers instructed to walk away and leave her" in these circumstances.
• We discussed this with the managing director of the service, to ask about their duty of care to the person. They told us there was a more up to date risk assessment in place, which we were shown. This also instructed staff to "walk away and leave her." There was no information or guidance on what care workers should then do. For example, try again later, report to the office or advise someone else. This lack of guidance could exacerbate the likelihood of the person developing pressure wounds.

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 12 (Safe Care and Treatment) of the Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff undertook training in safety systems, processes and practices in order to support people appropriately. For example, moving and handling training and first aid.

Using medicines safely

At our last inspection the provider had failed to ensure the proper and safe management of medicines. This was a breach of regulation 12 (Safe Care and Treatment) 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 12.

• People's medicines were not always managed safely.
• In one file, the person was prescribed an emergency or 'rescue' medicine, to manage their epilepsy. Sometimes seizures do not stop or one seizure follows another without the person recovering in between. When a seizure goes on for five minutes or more it is called status epilepticus (or 'status' for short). Status during a tonic clonic (convulsive) seizure is a medical emergency and needs urgent treatment with emergency medicine.
• It is important that every individual who is prescribed sedative rescue medicine has a written plan (or protocol) about when they are given the medicine. Although it is rare, these emergency drugs can cause breathing difficulties so the person must be closely watched until they have fully recovered. There was guidance on when to use the medicine, but there was no risk assessment about management of the person's epilepsy or the use of the emergency medicine. This could place the person at risk of harm.
• Specialist training is needed to give emergency medicines. Staff had not received this. This placed people at risk of harm.
• Care workers were not observed or assessed to check their competency to administer medicines, to ensure this was done safely. This was contrary to good practice guidance on supporting people with medicines in the community.
• Records of medicines administration were not consistently in good order. Care workers handwrote onto record sheets when they had administered medicines. Some of the writing was illegible, the strength of the medicine was not always recorded nor the amount given if it was a variable dose. For example, one or two tablets to be taken.
• Some people's medicines were given to them from a 'dossette' box which had been prepared by a pharmacist. Care workers had written 'dossette' box on the record sheets. However, where medicines are recorded as 'dossette', there needs to be an accurate record of the medicines contained in the dossette, so it is clear what was given to the person. We only saw evidence of a record of prescribed medicines in one of the files we checked. This meant there was not always a proper audit trail of the medicines given to people.

We found no evidence that people had been harmed however, 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.

• People told us their medicines were given to them at the right times.

Systems and processes to safeguard people from the risk of abuse;

At our last inspection the provider had failed to ensure people were protected from the risk of abuse. This was a breach of regulation 12 (Safe Care and Treatment) 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 12.

• People were not sufficiently protected from the risk of abuse.
• The safeguarding policy did not make any reference to the need to inform us about any allegations or suspicions of abuse. This meant the service did not have appropriate systems in place to respond to allegations of abuse.
• The service did not always know when to make appropriate referral to the local authority safeguarding team. Some referrals had been made. However, a complaint record showed a person had not received planned visits by care workers on two occasions and went without food, drink and medicine. The registered manager was unaware of the need to let the local authority know about these incidents of neglect.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate people were sufficiently safeguarded from the risk of abuse. 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.

• People told us they felt safe with the service they received from Universal Care Beaconsfield. Comments included "Absolutely safe. I can't praise them enough. They're really accommodating. They really bend over backwards." "They're very honest. I have regular ladies." "Totally safe." "I do feel (my relative) is safe." A relative said they felt safe because "We have a consistent carer and (my relative) knows her very well."
• There was training for staff on safeguarding. Staff did not express any concerns about people's care when we asked them.

Staffing and recruitment

At our last inspection the provider had failed to ensure robust recruitment practices were in place to protect people from the risk of harm. This was a breach of regulation 19 (Fit and Proper Persons Employed) 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 19.

• People were not always supported by staff who had been recruited using robust processes.
• Recruitment files showed the service carried out a range of checks which included obtaining references, completion of an application form and verification of identity. In three of the four files we looked at, an enhanced level check had been carried out for criminal convictions and inclusion on lists of people unsuitable to work with vulnerable people. This is a Disclosure and Barring Service check (DBS).
• In the fourth file, the member of staff had started work in December 2018 using their Disclosure and Barring Service check (DBS) from their previous employment. This had only been carried out at basic level, which would not have included the full range of required checking for care workers. An enhanced level DBS check was completed in February 2019. The registered manager told us it had been their decision to employ the person with just the basic level DBS, as they had obtained references and they considered there was little risk. We asked what measures had been put in place to monitor and supervise the person whilst they carried out their role as a live-in care worker. The registered manager was unable to provide us with evidence of any

checks taking place or any risk assessment for the situation.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate staff recruitment procedures were effectively managed. This placed people at risk of harm. This was a continued breach of regulation 19 (Fit and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People spoke positively of the support they received.
• People told us "Occasionally if they can't be on time, they will ring and tell me they're delayed." "There are currently changes going on in the office. Someone else is doing the rotas now and that is better. Occasionally there's been a slight change in times and we haven't been told…I think the office staff have been more attuned to carers' and clients' needs recently, for example, leaving enough time for travelling in between calls." "There are some carers who will work extra or unusual shifts. They are willing to do more than you would reasonably expect." "In general I'm pretty happy with them… very good timekeeping, they're never late. In general it's the same carers. I ask for them and they provide them. If they can't come (the office) explains why they cannot." "The office would always call if a carer can't turn up or if someone different will come, or no one at all."
• Staff told us there were back-up systems if they needed support in an emergency. For example, one care worker said "The Universal Care staff from top to bottom are helpful, caring, supportive, especially the managers who are always there 24 hours." Another care worker told us "I always feel that there is support and advice available if I need it. My emails are replied to promptly and I never have trouble reaching advice on the phone. I feel like my issues are taken seriously."

Preventing and controlling infection
• People were protected from the risk of infection during the provision of their care.
• Care workers had undertaken training in infection control practice.
• There were infection control procedures in place at the service.
• Care workers were provided with any personal protective items they required, such as disposable gloves and aprons.

Learning lessons when things go wrong
• The registered manager had not consistently taken appropriate action when things went wrong. For example, informing other agencies about all safeguarding concerns.
• We saw action was taken where staff had not carried out care to the expected standards. For example, supervision was held or a telephone call was made to discuss the issue. In one case we saw the result of an undated medicine audit said the care worker should receive a spot check. Staff in the office said this had not been carried out yet.
• Other agencies were contacted for advice. For example, occupational therapists, to see if there was equipment or other measures to prevent accidents or injuries to people.

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.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

At our last inspection the provider had failed to ensure people were protected from the risk of harm as care assessments were not sufficient to ensure they received safe and effective care. This was a breach of regulation 12 (Safe Care and Treatment) 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 12.

• People's needs were assessed by the service. Assessments took into account physical and mental health needs and any needs related to disabilities and communication. However, important information was omitted in some care plans, which could have serious repercussions for people.
• In one of the files, we saw the person was prescribed an anti-coagulant, to thin their blood and prevent the risk of a clot forming. There was no guidance in place to alert staff to the side effects from the use of anti-coagulant therapy, such as prolonged bleeding and coughing up blood, and what they should do if any of these side effects were noticed.
• Records in another file said "there is fluid thickener in the kitchen." Thickeners are used where people have swallowing difficulties, as a way of reducing the likelihood of choking. There was no guidance for staff about how much thickener to use per measured amount of fluid. There was also no mention of any swallowing assessment which may have pre-determined why thickener was required. This meant the risk from choking had not been sufficiently mitigated.
• In a further file, the person required PEG feeding. There was no guidance on how this should be done, the amount of nutritional feed to be given and how to flush the PEG with water before and after use, to prevent blockage. This meant the person may not be receiving care in a safe and effective way.
• One person's assessment from their funding authority said they had sleep apnoea. This was not mentioned in the care plan. The managing director told us the care plan was to be read in conjunction with the assessment by the funding authority. However, the service had not taken its responsibilities seriously by providing an appropriate level of guidance for its care workers. 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 safety was effectively managed. 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.

• Feedback from people was positive. Comments included "They have been brilliant. I have liked everybody who has come in. I have never felt uncomfortable leaving him in their care." "They're always on time. I find them excellent and it's helpful that we usually get regular people. The ones that come are used to (my relative) and are very patient."
• Care plans were in place for each person. We saw some evidence of people's choices and preferences being incorporated into their care plans.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure people were cared for by staff who received appropriate support and training to meet their needs. This was a breach of regulation 18 (Staffing) 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 18.

• People were not always cared for by staff who received appropriate support for the roles they were expected to undertake.
• There was a four day induction course for new starters which included training the provider considered mandatory. It did not include any observation or assessment of care workers out in the community.
• Staff were not completing the Care Certificate. This is a set of national standards which health and social care workers need to demonstrate in their work. It includes training, observation and assessment of staff. When we asked about the Care Certificate, we were told it had "fallen by the wayside." This meant people could not be confident care workers had the introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.
• Frequency of staff supervision was variable in the sample of files we checked. In one file the care worker had only received supervision once in their three months at the service, in another file the member of staff had not received any supervision in their first three months. In a further file, the member of staff had not been supervised since 2018. There was no evidence of other support made available to staff in the absence of supervision records, such as telephone calls. Two other files showed more regular patterns of supervision.
• We asked the managing director how often supervision should take place and were told at least twice a year, plus an annual appraisal and a spot check. We did not see any evidence of appraisals in the files we checked.
• There were no records of any probationary assessments or other methods being completed for new staff, before they were confirmed in post. The managing director told us there was no system for doing these at the service. This meant performance had not been effectively evaluated.
• We asked about spot checks. The registered manager told us these were not part of the supervision arrangements at the service. This meant there was no robust system to assess how effectively staff carried out their work in people's homes.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate staffing was effectively managed. 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.

• We found improvements had been made to training. For example, safeguarding training had been completed and all care workers attended dementia awareness courses.

• Comments from care workers included "Training is offered regularly and refresher as well, which is always useful to keep updated with legislation." "The service is excellent. I have been supported well." "The training providers have been very interesting and informative and welcome to questions."

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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

At our last inspection the provider had failed to ensure people's consent to their care was always obtained. This was a breach of regulation 11 (Need for Consent) 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 11.

• Where people lacked capacity, the service did not always provide care and treatment in line with legislation and best practice.
• Care plan documents contained information about people's resuscitation wishes, any living wills or advanced directives and whether they had a legally-appointed representative to make decisions on their behalf, such as a Lasting Power of Attorney (LPA).
• The service had obtained confirmation about who had legal authority in some cases but not in four of the care files we checked. In a further file, information said a family member had LPA for both health and welfare plus property and finances. The certified copy of the LPA was for health and welfare only. This meant the service had not taken appropriate measures to ensure it consulted with those who had the legal authority to act on people's behalf.
• We asked for examples of the service holding and recording best interest meetings to discuss the welfare needs of people who lacked capacity. The registered manager told us they did not support anyone where this was necessary. However, we saw two examples where it was probably necessary. One had involved the local authority holding a best interest meeting and the other was communication by the registered manager to an external agency to request meeting to discuss the person's care. We could not be certain the service followed the principles of the MCA in relation to best interest decision-making, due to a lack of records.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate that consent was effectively managed. This placed people at risk of unlawful practices. This was a continued breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People who had capacity were able to consent to their care and treatment. For example, a relative told us "On occasions (my relative) has said 'No'. For example, he does not want to get into his pyjamas and they do

listen to him. If they are doubtful, they come and ask me." "They are very encouraging at making him make his own decisions. For example, they get him to choose what he wants to eat."

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- People's nutritional needs were being met where this was part of their agreed care package.
- People told us their care workers provided them with the meals they liked and enjoyed.
- We asked people what care workers did if they felt unwell and whether they contacted their GPs or emergency services, if need be. Comments included "The carers spot signs of urinary tract infection. This morning they suggested I call the nurses to arrange a test. I find them excellent at keeping an eye on things like that."
- We saw the service had referred and liaised with healthcare agencies about people's care. For example, GPs, occupational therapists and emergency services.
- Staff worked well together and with external agencies.

Good

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 requires improvement. At this inspection this key question has now improved to good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

There are nine characteristics protected under the Equality Act 2010. These are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

At our last inspection we recommended the provider reviewed their operation in relation to people with protected characteristics. The provider had made some improvements but more were needed.

• The service provided care to people with a range of needs and abilities. A policy had been developed around the protected characteristics of the Equality Act 2010, but this was wholly focused on employees and not people who used the service.

We recommend further work is undertaken to demonstrate the requirements of the Equality Act 2010, in relation to people who use the service.

• People were happy with the care and support they received and felt they were well treated.
• Comments included "They all seem very nice. They're very caring and nice to (my relative), they're interested in her." "They are very nice. There's only been one I didn't like. I told the office and I've not seen them since." "They're marvellous. We couldn't do without them. The person (care worker) who stays one day…is just like a daughter." "Most of them have a good rapport with him. That's how I judge them, how they get on with him. At the moment there's nobody he doesn't get on with." "There are some of them who go beyond what you would expect. For example, they always make me feel relaxed. I can discuss anything with them, what they are doing and why they are doing it."
• All care workers were becoming dementia friends champions. This is an initiative set up by the Alzheimer's Society to promote the well-being of people with dementia in the community and increase awareness about how the condition affects people.

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care
• People's privacy and dignity were respected and they were encouraged to be independent.
• People's comments included "They're very discreet" when we asked about privacy and dignity. Another person said "There are never any problems about that, they're usually laughing and we have a chat and a

cup of tea."
• We asked if people were supported to be independent. One person said "They allow him to do what he is trying to do even if it takes time. If he wants to do something himself they will let him. All of them are very good humoured and they jolly him along. They are very respectful." A relative told us "They try to get him to walk to the bathroom using his walker rather than his wheelchair," to encourage independence.
• People were involved in reviews of their care and had opportunities to express their views.
• Surveys were sent to people to ask for their views about the care they received. Initial feedback from 2019 surveys showed a high level of satisfaction from people who used the service.

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. 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 the provider had failed to ensure the care and treatment of service users was appropriate, met their needs and reflected their preferences. 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 not enough improvement had been made and the provider was still in breach of regulation 9.

• Systems at the service were not robust enough to ensure people received personalised care which met their needs and preferences.
• The service supported people at the end of life. We read the care plan of someone who received end of life support. An assessment by the funding authority mentioned the person was supported by palliative care nurses. This was not mentioned in the service's care plan.
• The care plan had not been signed or dated. There was no indication if the person and/or their next of kin had been involved with it, to record their wishes.
• We asked the managing director about this. They said there was intention to go out and re-assesses the person's needs. For end of life care, it would be particularly important to make sure needs and wishes were taken into account at the first assessment and then kept under regular review. We asked if there was a specific care plan template for end of life care planning. We were told this was not in place. This was also the case at the last inspection.

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 9 (Person-centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Care plans were in place for each person. Background information was included about other household members, their roles and any pets.
• One person spoke with us about how their care plan was put in place. They commented "She (the member of staff) has such a sympathetic caring manner…I was very satisfied. She did a very professional job."
• We saw people were referred to other agencies where there were concerns about their changing care needs. For example, for moving and handling assessments. Staff at the service also contacted people's

relatives to discuss concerns and agree the best way forward. Meetings were held at the service involving managers and the dementia care adviser, to discuss people's welfare.
• Links had been made with local hospices and there were ideas to look into joint ways of working.

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 we made a recommendation for the provider to review its operation in relation to the AIS. At that time we reported about this under the Caring domain. The provider had made some improvements.

• We saw people's communication needs were assessed as part of their initial and on-going care needs assessments.
• The service had developed an AIS policy. This referred only to people with learning disabilities. However, the AIS applies to anyone with a disability, impairment or sensory loss. The policy and understanding of the AIS were not sufficient to ensure people's communication needs could always be met.

We recommend further work is carried out to improve how the service can fully meet the Accessible Information Standard.

• A relative told us their family member used a communication device. They added "All of the carers are willing to wait while he uses it, which takes a while, and they listen to what he says. (My relative) is always included in conversations. They are very much mindful of (my relative) and talk to him."

Improving care quality in response to complaints or concerns

At our last inspection we recommended the service sought advice about the management of and learning from complaints. The provider had made improvements.

• People's complaints and concerns were listened to and used to improve the service.
• People told us they would be confident making a complaint.
• A record was kept of complaints and how they had been responded to. Five complaints had been received since the last inspection. Records showed each complaint had been investigated by the managing director and a prompt written response was sent to complainants. Records showed appropriate actions had been taken in response to people's complaints and to prevent recurrence of issues.
• We saw numerous compliments had been received about the service.

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 requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection 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 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.

• There was a registered manager in post. The findings from the last inspection and this one demonstrated they did not fully understand their responsibilities towards meeting the regulations and providing high quality care.
• The registered manager told us in the PIR they were part of local and national forums to share good practice. We did not always see good practice in place at the service. For example, end of life care planning was not effective, care workers were not completing the Care Certificate and policies around the Accessible Information Standard, safeguarding and the Equality Act 2010 were not satisfactory.
• There were some quality assurance processes in place. For example, medicines audits. There were no audits of care plans to ensure these were comprehensive, always met people's needs and contained assessments for all known risks, to prevent avoidable harm.
• Spot checks were not carried out to assess care workers' performance out in the community. When we discussed this with the registered manager, they did not see the merit in this.
• There was no observed assessment of care workers' competency to administer medicines before they were permitted to handle them alone. We were told there was a written exercise as part of the medicines training. There was a lack of understanding of the need to formally assess care workers' practice over a series of observations, to ensure people received their medicines safely.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate that governance of the service was effectively managed. This placed people at risk of receiving unsafe or ineffective care. This was a continued breach of regulation 17 (Good Governance) of

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

• Providers and registered managers are required to inform us of specific incidents which have occurred during, or as a result of, the provision of care and support to people. We came across two safeguarding concerns, one regarding medicines, the other about neglect through missed visits. The registered manager had referred the first example to the local authority but not the second. They had not ensured we had been notified of either incident.

This was a breach of regulation 18 (Notification of Other Incidents) 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 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. The registered manager was aware of their legal obligations in the duty of candour process.
• The service had developed a duty of candour policy since the last inspection. We could see the principles of duty of candour were applied, for example, in response to complaints.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• People spoke positively of the service they received. Comments included "The agency is only as good as its carers and I've got a good one." "We are completely happy. I would give them ten out of ten. If we were dissatisfied we would immediately call them." "There's nothing we are not happy with." "I've been really satisfied with them. We've had a lot of girls, they've all been very good." "The carers are very good, very conscientious." "Sometimes things happen and they have to re-schedule a call and they will ring me. They always answer the phone, they're very good at that. I asked if they could make the bed time call earlier and they've done that. I've been very satisfied, I've recommended them to friends."
• A care worker said "I felt deflated with the result of the previous CQC report and I hope that the needed improvements have been made. I definitely believe that the recent acquisition of (name of manager) has made a big difference to the management team. (They have) supervised many of the carers, including myself, employed extra staff and created new positions in administration to help keep the service regulated and safe."
• Care workers described an open and inclusive workplace where they could express themselves. We asked if staff would feel confident raising any concerns. Comments included "Yes, definitely," "I have none (concerns) but if I did I am confident to discuss with anyone in the office, manager, or higher. All are very helpful and supportive." "I have every confidence in raising concerns to the management team." They added "I was made to feel comfortable and that I was doing the right thing" when they discussed some concerns.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
• Some of the people we spoke with told us they were involved in drawing up their care plans. Comments included "A manager came and spoke to me for quite a while asking what I wanted and when I wanted calls. The morning call was 9:00 a.m. which didn't suit so well so I asked if we could change it to 10:00 and they

did." "We went through in detail the (care) needs and showed them what had to be done in the house."
• The service worked with other organisations to ensure people received effective and continuous care. For example, healthcare professionals.
• People told us they were kept informed. Comments included "The office keeps in touch and informs us as and when they have to change the person who is going to call." "Even when they had some problems…they were good at getting back to us." "The office are brilliant. I can't say enough good things about them. They keep in contact and if there's anything happened they let me know and what they are doing about it." "(Name of member of staff) in the office is brilliant. They always keep in touch. She sent me a letter of who to contact when she was going away."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person had not notified the Commission without delay of the incidents specified in the regulation: any abuse or allegation of abuse in relation to a service user. Regulation 18 (2)(e)

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 9 HSCA RA Regulations 2014 Person-centred care Service users' care plans were not robust enough to ensure they received personalised care which met their needs and preferences. Regulation 9(1)

The enforcement action we took:

NoP served on provider to cancel registration

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not always provided in line with the Mental Capacity Act 2005 and best practice, to uphold service users' rights. Regulation 11(1)(3)

The enforcement action we took:

NoP served on provider to cancel registration

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not assessed the risks to the health and safety of service users and done all that is reasonably practicable to mitigate any such risks. The provider had not ensured the proper and safe management of medicines. Regulation 12(2) (a)(b)(g)

The enforcement action we took:

NoP served on provider to cancel registration

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not always adequately protected from abuse or the risk of improper treatment as systems and process were not operated effectively at the service. Regulation 13(1)(2)

The enforcement action we took:

NoP served on provider to cancel registration

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have adequate systems in place to assess, monitor and improve the quality and safety of service users' care. Regulation 17(1)

The enforcement action we took:

NoP served on provider to cancel registration

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not operated effectively to ensure service users were always supported by care workers who were of good character. Regulation 19(1)(3)

The enforcement action we took:

NoP served on provider to cancel registration

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured persons employed received appropriate support, training, professional development, supervision and appraisal to enable them to carry out the duties they are employed to perform.

Regulation 18(2) (a)

The enforcement action we took:

NoP served on provider to cancel registration