Universal Care Limited

Universal Care - Beaconsfield

Inspection report

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16 June 2020
17 June 2020
18 June 2020
19 June 2020

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

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 approximately 140 people.

People's experience of using this service and what we found
We found people were placed at continued risk of avoidable harm. The provider had not always identified or assessed risks posed to people. The provider did not always ensure people's needs were assessed prior to supporting them.

People were supported by staff who had not received training to care for them safely. People with end of life care needs had been supported by staff who had not received any end of life training, We found staff were not equipped or trained to deal with emergency situations.

People were supported by staff with prescribed medicines which were not always listed on their care plan.

The provider has an inspection history of ineffective management. At this inspection we found an ongoing lack of leadership and skills to manage the service. Records were not routinely updated to reflect people's needs or decisions made about their care and support. We found the provider continued to fail to meet the fundamental standards and meet the requirements of the regulations.

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 13 May 2020). At this inspection enough improvement had not been made or sustained and the provider was still in breach of regulations. We have not changed the rating as this was a targeted inspection.

Why we inspected
We undertook this targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to ongoing concerns received about risk management, assessment of needs and the lack of effective managerial oversight. A decision was made for us to inspect and examine those risks.

CQC have introduced targeted inspections to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key

question.

Enforcement
We have identified repeated and continued breaches in relation to risk management, record keeping related to supporting people, medicine management and staff training. The provider has continued to fail to notify CQC of certain events and monitor and improve the quality of the service to people.

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

Follow up
Since the last comprehensive inspection in March 2020 we have met with the provider to seek reassurance on the improvements they intend to make. We will continue to work with the provider with support from the local authority to ensure they improve their rating to at least good. 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' and has been since the 2019 inspection. This means we will keep the service under review and monitor their improvement action plan. 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 use our powers and 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 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.	**Inspected but not rated**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inspected but not rated**

Universal Care - Beaconsfield

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to follow up on concerns we had about continued breaches of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to the management and assessment of risk. We also had concerns about continued breaches of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to record management and effective systems to ensure people were kept free from harm. We looked at staff training as we were concerned about a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspection team
The inspection team consisted of one inspector, one inspection manager and one 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
This inspection was unannounced.

Inspection activity started on 16 June 2020 and ended on 19 June 2020. We visited the office location on 16 June 2020.

What we did before the 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 since the last inspection. We used all of this information to plan our inspection.

During the inspection-
We spoke with two people who used the service and two relatives about their experience of the care provided. We spoke with the provider and registered manager who was the same person. We spoke with a further nine members of staff including care co-ordinators, a field care supervisor and care workers.

We reviewed a range of records. This included 14 people's care records and four medicine records. We looked at five staff files. We looked at accident and incident records, complaint records and medicine audits.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested a number of documents from the provider which were not sent within the timescales we requested. We spoke with a representative from the local authority and one healthcare professionals who had knowledge about one person.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about. The service remains inadequate in this domain. This meant people were not safe and were at risk of avoidable harm.

The purpose of this inspection was to check specific concerns we had about the management of risks posed to people and how they were mitigated. We also checked how the provider ensured lessons were learnt and improvements made. We will assess all of the key question at the next comprehensive inspection of the service.

Assessing risk, safety monitoring and management

At our inspection in June 2018 the provider had failed to assess the risks to the health and safety of people receiving care. 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 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 the last inspection in March 2020 we found the provider was in 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 effectively protected from potential avoidable harm. We found the provider had not ensured they had done all that was reasonably practicable to mitigate risks. Risk assessments had not always been completed when required. One person's care needs assessment identified they slept in a hospital bed with rails and had a pressure relieving mattress. No risk assessments were in place for the bed rails and risk of pressure damage. We asked the registered manager if any had been completed and they confirmed the risk assessment had not been completed. The same care needs assessment identified the person required a fall risk assessment. No fall risk assessment was in place. The registered manager confirmed one had not been completed. This meant staff had no guidance on how to manage potential risk posed to people and placed them in danger of avoidable harm.
●Care plans were not updated to reflect changing needs. One person had fallen twice in May 2020, following both falls, they had been admitted to hospital for a head scan. They were assessed by hospital staff prior to each discharge and equipment had been provided to support with their changed needs. We asked the registered manager if the person's care plan and risk assessment had been updated to reflect the changes. The registered manager sent us an updated care plan and risk assessment which had been written one week after the person was discharged from hospital and four days after our request. This meant the provider had not reviewed the risk assessments or care plans prior to each discharge from hospital which had the potential to put the person at risk.

●People's needs were not assessed to reflect their medical conditions. One person had received support from the service in March 2020. We checked if an assessment of need had been completed prior to them being supported. We found the last assessment had been completed in 2018. This meant there was no evidence the person's medical condition or level of support had been assessed prior to them being supported. We asked the registered manager for an explanation and they told us "We were not informed by the client or his wife about his [name of medical condition]". This demonstrated a lack of understanding and responsibility regarding the provider's requirements under the Health and Social Care Act 2008.
●People's needs were not re assessed when their condition changed. One person had fallen three times in March 2020. As a result, their needs had changed. We checked if any re-assessment had been made. We found no records of a re-assessment, we asked the registered manager if they had arranged or conducted a re-assessment, they confirmed the last assessment was carried out in 2018. The person had been admitted to hospital following a marked deterioration in their health. We have since been informed the person was admitted with pressure damage as a result of care workers from the service making a temporary bed on the floor as the person was unable to walk upstairs. The registered person's and staff had failed to support the person when their needs had changed or seek timely and appropriate external healthcare support. The person was admitted to hospital following the return of their relative who immediately sought medical attention to the deterioration in their health.
●At the inspections carried out in 2019 and 2020 we highlighted our concerns about the provider's failure to adequately assess the risks posed to people who were prescribed anticoagulant medicine. There was no guidance in place to alert staff to the side effects from the use of anticoagulant therapy. People who were prescribed anticoagulant could be at an increased risk, which could include bleeding and coughing up blood. One person had been assessed by the service on 15 April 2020. Their assessment stated they were prescribed an anticoagulant medicine. We checked if a risk assessment had been completed. The registered manager confirmed with us on 19 June 2020 no risk assessment was in place to advise staff on how they should observe for any signs of bleeding and what they should do if any other side effects were noticed.
●We checked other people's records who were also prescribed anticoagulant medicine we found there was no risk assessment in place. We asked the registered manager to explain and they told us "In relation to risks of using anti-coagulant medication our policy is to include a warning at the top of the client profile and to indicate by the side of the anti-coagulant medication that in the case of bleeding 999 should be called." However, we found this was not the case in all records we looked at. We found this guidance when recorded placed people who were at risk of falling were at an increased risk of harm, as no guidance was available for staff.
●People were not routinely supported safely with their prescribed medicines. The provider had continued to fail to assess the support people required with medicines. People were being supported with medicines which had the potential of abuse due to their addictive nature without any guidance for staff on how they should be administered safely. We found medicine records did not routinely record what staff should administer. One person had an assessment of their care needs dated 28 November 2019. It stated they did not take any medicine. When we inspected in March 2020, we found the person had been commenced on a medicine in the afternoons. Records showed staff had been advised of this in a team meeting and daily care records showed staff had administered the medicine. The care plan and medicine record had not been updated to reflect this. At this inspection we found completed "medication charts" for May 2020, these showed staff had not only been administering the medicine in the afternoon as found in March 2020, but had also been administering pain relief, skin creams and vitamins. Therefore, this placed people at risk of harm of unsafe medicine practice.

This was a continued breach of regulation12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our inspection in June 2018 the provider had failed to ensure staff received appropriate training and supervision as was necessary to enable them to carry out the duties they were 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 inspection in August 2019 we found not enough improvement had been made in relation to staff training and the provider was still in breach of regulation 18. At the last inspection in March 2020 we found some improvements had been made, but the provider remained in breach of regulation 18. This was because risks to people were not always mitigated because of continued gaps in training.

At this inspection we found people were being supported by staff who did not hold the right skills, competence and experience to support them safely.

● Staff who were supporting people who had fallen or had become unwell or died had not received first aid training. We asked the provider what training staff had received. They sent us a leaflet which was handed to staff on their induction. This stated in an emergency staff should "Gently shake their shoulders and ask loudly "Are you alright?" Another document was contradictory in its nature as one section stated, "Our carers are not trained to resuscitate" and in the same document it describes how staff should undertake cardiopulmonary resuscitation. This guidance had not been updated to reflect best practice given the current global pandemic.
● The provider's accident policy stated, "All staff will receive induction training and updates on all aspects of safe working practice, including reporting procedures in the case of accidents and untoward incidents". However staff told us "I haven't had any training in emergency first aid" and "I've done that years ago but not with Universal Care". We checked staff training records and spoke with a member of staff who managed recruitment and training who confirmed the records we looked at were accurate. We found staff had not been adequately equipped to deal with emergency situations due to the lack of training provided.
●There was ineffective moving and handling training in place for staff to use equipment safely. Staff told us they had not received competency training regarding the use of moving and positioning equipment. One member of staff told us "Clients I've got now I am using Sara steady. No one came yet to asses me, I just started using it last month" and "I had training, but no competencies".
●Staff who supported people with end of life care needs had not always received adequate training in end of life needs or emergency first aid. This placed people at risk of receiving inappropriate or incorrect care. We checked with a member of staff if training had been arranged and they told us the trainer who delivered end of life training had left the company over a year ago and no staff had received any training since then. Following the inspection the registered manager confirmed end of life training had since been arranged.

This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

At our 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 experience of people 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 from 2018 of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the last inspection in March 2020 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 systems 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.

●We found the provider had not acted upon our previous concerns. At this inspection we continued to find lessons were not learnt from when things went wrong. We spoke with the registered manager about one incident. They told us they were not aware of it. Following the discussion, the registered manager told us "I was not made aware as there was no injury and that follows our procedures." However, the service's policy states "The Registered Manager of Universal Care, in collaboration with staff, will be responsible for monitoring the pattern of accident reports and for arranging for investigations into reported accidents so that the root causes can be identified." We have no confidence the registered manager is aware of all accidents and has the ability to monitor and investigate to prevent a re-occurrence.

This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question, we had specific concerns about. The service remains inadequate in this domain. 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.

The purpose of this inspection was to check specific concerns we had about the management and leadership of the service. We will assess all of the key question at the next comprehensive inspection of the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

At our 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 the last inspection in March 2020 we found not enough improvement had been made and the provider was still in breach of regulation 17.

At this inspection we found a continued breach of regulation 17. We found the provider failed to assess, monitor and mitigate risks posed to people. We also found the provider did not maintain accurate and complete records of decisions made about people's care.

- The provider did not ensure records held either on paper or electronically reflected people's care. One person who had been supported in March 2020 had no records relating to their care from 2019. We found the person's needs had changed and they had fallen, and no records existed about the event. We were advised from the local authority who had been conducting a safeguarding investigation into the case of discussions held by the service at the time of the falls. However, no records were available. The local authority had provided us with statements from staff. One statement referred to a telephone call to the registered manager. We found no record of the call. We asked the registered manager to explain why the call had not been recorded they told us "It was an error". We checked other records and found communication to the office was not routinely recorded. This placed people at risk as information about people's changed needs was not always communicated.
- Records regarding the management of risks, staff training, and medicine management were not always updated in a timely manner. There were delays in risk assessments being updated and medicine records did not always reflect people prescribed medicines.

●The provider had not learnt from our feedback at the last inspection. For instance, they had failed to look at mitigating risks posed to people who were prescribed anticoagulant medicines.

This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At the inspection in 2019 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 the last inspection in March 2020 we found some improvements had been made. However, not all reportable events were notified to us. We found this was a continued breach of regulation 18 (Notifications of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

At this inspection we found a continued breach of regulation 18.

●In May 2020, the registered manager made a statutory notification of an allegation of abuse to us regarding an event that occurred in March 2020. Following the notification, we found the registered manager was made aware of the allegation in March 2020. However, they had failed to notify us at the time. This occurred on the third day of our last inspection. We had spent some time with the registered manager explaining when they should notify us of certain events. At this inspection we asked the registered manager for an explanation as to why they did not notify us sooner. They told us "I should have made a statutory notification to you earlier."
●We found one person had been admitted to hospital twice with a suspected head injury following falls. No statutory notifications were made for the falls. We discussed this with the registered manager who told us they did not consider the falls to be reportable. However, the person was on blood thinning medicines and had hit their head on each fall. They had been taken to hospital for a head scan. We consider these were notifiable safety incidents.

This was a continued breach of regulation 18 (Notification of Other Incidents) of the Care Quality Commission (Registration) Regulations 2009.

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 provider failed to make all the required notifications to the CQC.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess the risks to the health and safety of service users. The provider failed to ensure service users who were supported with the management of their prescribed medicines had support from staff which followed best practice guidelines.

The enforcement action we took:

We issued an urgent notice of decision to impose a condition on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to maintain and accurate and contemporaneous record in respect of decision taken about care and treatment. The provider failed to assess, monitor and mitigate the risk relating to the health and safety and welfare of service users.

The enforcement action we took:

We issued an urgent notice of decision to impose a condition on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure staff had received the training required for them to carry out the duties they were employed to perform.

The enforcement action we took:

We issued an urgent notice of decision to impose a condition on the provider's registration.