

# Universal Care Limited

# Universal Care - Beaconsfield

## Inspection report

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13 June 2018

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## Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

**Requires Improvement** ●

Is the service effective?

**Requires Improvement** ●

Is the service caring?

**Requires Improvement** ●

Is the service responsive?

**Requires Improvement** ●

Is the service well-led?

**Requires Improvement** ●

# Summary of findings

## Overall summary

The previous inspection took place in November 2016. The overall rating from that inspection was requires improvement. This announced inspection took place on 11, 13 and 14 June 2018. This is the second consecutive time the service has been rated Requires Improvement.

At the last inspection on 23 and 25 November 2016, we made recommendations for the provider to make improvements in record keeping in relation to safeguarding investigations. We also raised concerns as meetings between staff and managers were not always documented.

During this inspection we found records related to safeguarding concerns were up to date, however we had concerns related to a lack of knowledge and understanding of staff regarding the correct safeguarding procedure to follow. Records related to meetings between staff and managers were in place, however, the frequency of these meetings was not in line with the providers policy.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults, younger disabled adults and children. At the time of our inspection it was providing care to 218 people.

Not everyone using Universal Care – Beaconsfield receives a regulated activity. CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People, their relatives and professionals were generally very positive about the service provided. However, we had concerns about the safety of the recruitment system for employing new staff as not all relevant checks had been undertaken.

Care plans and risk assessments did not all contain relevant up to date and accurate information. This placed both people and the staff at risk of harm or injury.

Medicines were not safely managed, staff did not always receive up to date training and their competency was not always assessed. There were no effective medicine audits in place to protect people from harm.

People were not always protected from the risk of abuse, as staff training was not regularly up dated. Staff were not aware of how or who to report concerns of abuse to.

Training for staff was not comprehensive, and did not cover the areas they required to carry out their role. Support for staff through one to one supervisions and spot checks were not carried out in line with the provider's policy.

The service was not compliant with the requirements of the Mental Capacity Act 2005 (MCA) and associated codes of practice. People were not assisted to have maximum choice and control of their lives. There was a lack of training for staff and understanding by senior staff, to protect people from receiving inappropriate care.

People and their relatives described staff as caring, patient, and helpful. They gave us examples of how staff had gone above the call of duty to them.

The provider had failed to assess the service in relation to people with protected characteristics. They were not able to evidence how they were compliant with the Accessible Standards Framework. We have made a recommendation about this in the report.

People told us the staff protected their privacy and dignity when carrying out personal care.

The provider's documentation showed how they appeared to respond appropriately to complaints, this was not always the view of the complainant. Staff were not sure how to respond to complaints, and they had received no training in how to do so. We have made a recommendation about this in the report.

People did not always have an end of life care plans or associated risk assessments in place. Without this the provider could not be certain they would be providing care for people in line with their preferences and choices for their end of life care.

There had been a change in senior staff over the last few months; however, we found there were other inconsistencies in the management of the service. There had been weak leadership. Senior staff had not received adequate training to enable them to assess the skills of care staff. No audits were in place to ensure the quality of the service and make changes when necessary.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not safe.

Safe systems of employment did not protect people from the risk of being cared for by unsuitable staff.

People's medicine records did not demonstrate that medicines were administered safely and consistently by staff who had been trained.

Care plans and risk assessments did not always accurately describe the risks associated with people's health needs. This placed people at risk of receiving inappropriate care.

**Requires Improvement** ●

### Is the service effective?

The service was not effective.

Induction, training, supervision and reviews were not adequate for the needs of the staff. This placed people at risk of receiving unsafe care.

Staff were unable to demonstrate a clear understanding of the requirements of the Mental Capacity Act 2005. There was no documentation in relation to mental capacity and decision making.

Records showed people had access to health care appointments when needed. This ensured people's health needs were maintained.

**Requires Improvement** ●

### Is the service caring?

Some aspects of the service were not caring.

The service had not made provision for people with protected characteristics.

The provider failed to show a clear understanding and compliance with the Accessible Information Standards. This placed people with communication difficulties at a disadvantage.

**Requires Improvement** ●

Staff demonstrated how they protected people's privacy and dignity. They could give examples of how they showed respect to people.

### **Is the service responsive?**

The service was not responsive.

Care plans were not focussed on people's preferences or how they wished care to be provided. Without this people had limited choice and control over the care provided.

Staff did not always know how to deal with complaints. People's experience of making complaints was not always responded to in an encouraging way.

**Requires Improvement** ●

### **Is the service well-led?**

The service was not well led.

A lack of quality monitoring in some areas such as medicines records and care records meant improvements had not been identified or implemented.

The service was not compliant with The General Data Protection Regulation (GDPR). This meant people's personal data had not been protected.

A lack of managerial oversight, strong leadership and a clear vision meant the service was not providing safe and effective care. This had not been identified by the registered manager.

**Requires Improvement** ●

# Universal Care - Beaconsfield

## **Detailed findings**

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We gave the service 48 hours' notice of the inspection visit because we needed to be sure that staff would be available to assist us with our inspection.

Inspection site visit activity took place on 13 June 2018. It included visiting two people in their own homes and speaking to three staff. We visited the office location on 11, 13 and 14 June 2018 to see the manager and office staff; and to review care records and policies and procedures.

The inspection was carried out by two inspectors and one expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. This expert had experience of supporting older and younger people and those living with dementia.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the completed PIR and used this to inform our inspection.

Prior to the inspection we sent out a questionnaire to people's relatives and friends, staff and professionals who were familiar with the service. We received nine responses from people's friends and relatives, three from community professionals and 47 from staff. We used the feedback we received to inform our inspection.

During the inspection we spoke with 11 care workers, two care managers, the training and recruitment

manager, and the registered manager. We also spoke with two professionals who supported the service around nursing and dementia awareness.

We spoke with seven people and five relatives. We reviewed a range of records about people's care and how the service was managed. This included 23 care plans and associated care records including for some medicines. We examined records in twelve staff files which included recruitment records, training, supervision and appraisal records. Other documents we viewed included safeguarding notifications, minutes of meetings with staff, and incident reports amongst others.

# Is the service safe?

## Our findings

In response to the questionnaires we sent people's relatives and friends all respondents told us they felt the service was safe. People we spoke with on the telephone echoed this. Comments included "We've been having support from this service or three years now, and it is safe." "I feel safe with this company." However, we had concerns about how the service operated in relation to staff recruitment, training and supporting staff.

This was because procedures used in the recruitment of new staff were not always robust. A full employment history had not been gained for all new staff. Gaps in employment had not been explored or explained. For example, in one file there was no record of employment from 1988 when the candidate left school to 1994 and then further gaps from 1996 to June 1997 and July 2011 to September 2011. For another two staff who had been employed references had not been obtained from their previous employer. In another file the member of staff had been employed at the service until June 2015 and had returned in January 2016. Although they had been interviewed before returning there was no explanation of what they had been doing during that period. Furthermore, no reference had been sought for that period. Other checks had been completed in line with the requirements of the regulations.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's health and well-being were not fully assessed. Risks associated with falls, skin integrity, nutrition and specific health conditions such as epilepsy and diabetes had been identified but no guidance or measures had been planned to reduce or mitigate those risks. For example, one person's care plan stated they were on a soft diet due to swallowing problems. There was no risk assessment or measures in place to reduce the risks to this person and there was therefore a risk of choking. In another person's file it stated they lived with a medical condition that required monitoring but again no detailed guidance was available to staff should the person's condition deteriorate.

Medicines were not managed safely. People signed an agreement to consent to assistance being provided with their medicines. However, it was not always clear from the care plans what if any assistance people required with their medicines. For example, they did not always record who ordered or collected people's medicines nor the assistance required. Neither was it clear how people liked to take their medicines.

Risk assessments had not been completed when people were prescribed such medicines as transdermal patches. A transdermal patch is medicated and provides medicine through the skin. This meant staff had no clear guidance on appropriate measures to take to reduce risks associated with these medicines. For example, one person's care plan indicated they needed a medicine patch changed every three days. It did not direct staff to remove the old patch or ensure the new patch was placed in a different location on their body to avoid the possibility of irritation or reaction.

In another person's care plan there was confusing information as to whether the person self-administered a

particular medicine or required staff to do this for them. The care plan indicated the person self-administered medicines, however, it was clear from the person's file, staff assisted them in measuring and drawing up the dose to be administered. It stated, "Staff must be confident in drawing up the [name of medicine]." Staff had not received any specialised training to do this and therefore there was a risk the person may receive too much or too little of the medicine. In the same person's file, it was noted that at a GP review in April 2018 the GP would be writing to the service about this particular medicine. However, there was no further correspondence and no evidence this had been followed up.

We saw one person was prescribed a medicine known as an anticoagulant. These medicines reduce the ability of the blood to clot. This is necessary to reduce the risk of conditions such as strokes or heart attacks. However, the medicine is a 'high risk' medicine and accurate recording of doses and administration is of paramount importance.

We saw poor recording of the administration of the person's medicine. For example, we found gaps in records related to the administration of the medicine. Charts we saw did not follow safe practice in relation to administration of this medicine as a result we could not confirm if the person had the medicine when they required it or the correct dose.

In addition, the dose of the medicine must be clearly stated on the medicine record and should be annotated 'refer to warfarin chart'. The service did not follow this practice which put the person at risk of serious health conditions.

We were told by the registered manager medicines were audited during visits by the care managers or care co-ordinators to review care or supervise care staff in people's homes. However, there were no records of medicines being audited at these visits and we could not be assured that there were processes in place to identify any errors that occurred. We saw there had been a number of medicine errors reported to the care managers by the local authority safeguarding team. These incidents involved medicines being missed or incorrect doses being given. Records showed these incidents had been investigated and where necessary staff had been spoken to and received refresher training in managing medicines. However, we found not all staff had up to date training in the administration of medicines. The provider had reviewed their medicines policy as a result of these safeguarding incidents; however it did not contain guidance on staff training, its frequency or checking competency.

People told us and staff confirmed there were sufficient numbers of staff employed by the service. Where possible the same staff cared for the same people. This enabled consistency of care.

Staff received training in assisting people with their medicines during their induction. However, we noted that the person responsible for delivering this training had no specific training to deliver this. They told us they were following a pre-designed presentation but said they did not have knowledge or skills relevant to this topic. The registered manager stated they should not have allowed this person to deliver the training and would look into the matter. Some staff had undertaken refresher training in managing medicines but again there was no consistency and it was not considered mandatory. We were informed care managers and care co-ordinators were responsible for checking staff competency in assisting with medicines. However, it was evident from records that those staff had not completed refresher training to ensure their own skills were up to date. Furthermore, there was no recorded evidence of staff competency being checked. Staff told us that when they were observed by a senior staff member it did not always include observing medicines being administered.

Staff were not always familiar with how to safeguard people from the risk of abuse and harm. When asked

about what action staff would take given a hypothetical safeguarding scenario three staff members were not clear what action to take. One told us they had not considered such a scenario and said, "I have no idea what I would do." Another told us they would contact social service or the citizen' advice bureaux and a third was unable to answer the question. This meant that people could be placed at risk of abuse.

There was no consistency in refreshing the training for staff in relation to safeguarding people. Staff had completed training in identifying and reporting issues and concerns relating to protecting people during their induction to the service. However, there was no systematic process to ensure they refreshed this or to check if their knowledge remained current. For example, seven staff records indicated they had not refreshed this training for over six years. Another three files showed no record at all of safeguarding training being undertaken. Furthermore, there was no evidence to show more senior staff were up to date in practices to protect people. We reviewed the files of two care managers and saw neither contained any reference to safeguarding training. We raised this with the registered manager who confirmed that safeguarding training was not considered a mandatory training topic for staff and therefore not automatically refreshed.

All these areas contributed to a breach of regulation. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was insufficient evidence to show that staff had received training in infection control. Documents did not reflect this had been completed by staff. We observed poor practice when we saw a staff member drop a number of a person's medicines onto their duvet by accident. The staff member picked up the medicines by hand and gave them to the person. Protective personal equipment such as gloves were available but the staff member did not use them. This placed both the person and the staff member at risk of contamination and infection.

## Is the service effective?

### Our findings

People's needs were assessed before they used the service and a care plan prepared. However, the detail of assessments varied greatly and there was lack of guidance for staff within some care plans. For example, one person's plan noted they required a soft diet and fluids needed to be thickened. However, there was no detail of what consistency of food was required, whether a speech and language assessment had been carried out or what type of foods the person liked. This placed the person at risk of choking. In another the assessment indicated the person required the use of a hoist to transfer. It stated the person would be able to tell the care staff which loops to use to attach the sling to the hoist. However, there was nothing recorded to guide staff if the person was unable to do this for any reason. In other files it noted such things as risks of falls, sensory deficits and poor skin integrity but there was little or no guidance as to how staff should manage or minimise risks associated with these.

Other people lived with health-related conditions such as epilepsy, diabetes and dementia. Their files did not contain any specific care plans for these conditions to assist staff to achieve effective outcomes for these people. For example, a person living with diabetes had no guidance in their care plan should they have a diabetic crisis and require intervention. In the file of a person living with epilepsy there was no indication of when medical help should be sought or what observations should be made.

This was a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always cared for by staff who were skilled to meet their individual needs. Staff praised the training they had received and told us it was of good quality however, said they did not feel there was enough. The registered manager told us and records confirmed that the only topic currently considered mandatory was moving and handling. We saw all staff refreshed this training every 18 months. All other training was completed when and if staff felt they required additional training or if an error had alerted senior staff to deem it necessary. One staff member told us, "There's a lot on the internet you can look at to help you." Training records were held on a computerised system. The way in which training was recorded was inconsistent; therefore, we were unable to gain a complete picture of the current skills of the staff team.

The provider's policy on staff training stated all care staff were encouraged to achieve at least a level two qualification in social care. The computer records indicated a number of staff had achieved this but there was no evidence in the way of certificates to corroborate this. The policy also referred to encouraging staff to attend "one off courses which may be advantageous in their role". However, there was no clear expectation made of staff to attend these sessions. From the records the majority of staff had not attended these sessions. This was concerning as staff were expected to carry out specific procedures such as stoma care, removal and application of medicated patches and blood glucose monitoring. These procedures require specialist skills for which they had not all received training. In addition to this staff were caring for people with conditions such as epilepsy and diabetes without having been trained in the skills necessary to care safely for these people.

All staff received a four-day induction to the service before they began work. The registered manager told us this had been improved since the previous inspection and extended to include a fourth day. The induction introduced staff to the service and covered an introduction to the standards of the care certificate. The care certificate is a set of standards adhered to by care staff in their daily work. However, we were told staff were not provided with further instruction on the care certificate standards and were not observed on each of the standards in order to ascertain their competency. Following the induction course, we were told each member of staff spent time shadowing a more experienced member of the team. The length of time they spent shadowing was dependent on their previous experience. There were no records to indicate how long staff had shadowed nor were there consistent records to show they had been observed at the end of this period to assure the provider of their competence.

Staff did not always receive support in their role. The provider's policy indicated each member of staff could expect to meet with a senior staff member three times per year. These meetings consisted of a one to one supervision session to discuss issues relating to work practice, a spot check on their care worker's practice and an annual appraisal. Again, recording of these meetings was inconsistent and showed these meetings were not always held regularly. In six files we saw either no meetings had been held for over a year or only one had been held. Staff however, told us they felt supported and confirmed there was always someone either in the office or on-call who could assist them if they needed help.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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's rights to make decisions and remain in control of their lives were not always respected. Not all staff had received training in the MCA and some were unable to tell us how the MCA applied to their work. The registered manager told us they thought all the people using the service had mental capacity. However, mental capacity assessments were not carried out when people's conditions deteriorated and therefore we could not be assured that appropriate steps had been taken to make decisions in people's best interests. The registered manager told us they did not believe it was the role of staff to carry out mental capacity assessments. This is not in line with the MCA code of practice.

We saw examples of people's choice not being respected and there was no evidence of best interest decisions being made on their behalf. For example, in one person's file there were notes from a meeting held in 2015 to discuss the possibility of using a stair gate to prevent the person wandering and potentially falling. The person is noted as saying they would "kick it" if it was put in place and clearly did not wish to have it fitted. At that time the notes recorded no action should be taken but if the gate was required in the future a best interest meeting should be held. It was evident from the records a stair gate had been fitted since that time as well as a sensor to alert staff if the person got out of bed. Staff confirmed no best interest meetings had been held and we were told the service had acted on the instructions of the person's care broker to fit them. The senior staff were not aware applications to the Court of Protection via the supervisory body would be required to restrict a person's liberty in their own home.

In another person's file it stated the person had limited mental capacity but their daughter would be on hand to make wise decisions on their behalf. While in a third file it was recorded that a person's relative had power of attorney to make decisions on their behalf. The records did not indicate which decisions they could make and staff confirmed they had not verified their right to do so. We asked if they sought verification

of power of attorney routinely when told one was in place. They confirmed this did not happen. The registered manager told us they were under the impression that verification was sought and said they would address this issue.

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

Staff provided assistance with meals for people who required this. Compliments had been received about people's meals where staff had prepared and cooked them. Staff recorded what people ate and told us they would report any change in appetite or any other significant changes to the care managers so referrals could be made to health professionals when required.

We saw staff had contacted people's GP if they had been unwell. Staff told us they checked with the person to see if they wanted to contact the GP before doing so and always informed the office. There were also records of staff contacting emergency services such as 111 or 999 when required.

## Is the service caring?

### Our findings

People and their relatives and friends told us the staff were caring in their approach and dealings when providing care. Comments included "The carers are timely, patient, and caring." "They are kind patient friendly and helpful." "The attitude of my carers is very good. They do the work happily."

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.

The Provider Information Return (PIR) was completed in November 2017 it requested the provider to inform us of the following "In the last 12 months have you done any specific work to ensure your service meets the needs of people with protected characteristics?" The answer provided was "yes" in the areas of race; age; disability and gender. We were not provided with evidence of this during the inspection. We asked one of the care managers if they were aware of people with protected characteristics, they were unaware of the terminology. When we explained they said, "I don't think we have anything for it." (Policies, procedures or guidance.) They checked with their colleague who agreed. They went on to tell us they did not discriminate as an organisation, and the training provided to staff around diversity and equality was provided during induction. The PIR stated no one had received training in this area in the previous 24 months, we found no record of training being delivered to staff in this area. For some staff this was 10 or more years since they had done any training in diversity and equality.

The Accessible Information Standards is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. We reviewed information that had recently been sent to people. No option was given to people to receive it in a different format or language. We were told by a care manager the dementia specialist who was employed as an advisor would be able to provide guidance for staff, however we did not see any evidence of this in people's care plans or in staff training records.

We recommend the provider reviews its operation in relation to people with protected characteristics and the Accessible Standards Framework.

People's likes, dislikes, preferences, personal interest and hobbies were not always recorded in care plans. Where this had happened, records did not include information to allow the person to exercise choice. For example, there was insufficient information about how a person liked to be supported with meals, the care plan stated "Feed [named person] his lunch, he has a good appetite." This part of the plan was not written in a way that was encouraging independence or demonstrating respect for the person. There was no reference to preference regarding the time of day or frequency.

Some care plans did contain people's personal histories and this allowed staff to be empathetic and understanding about people's pasts. It allowed where appropriate conversations and discussions including reminiscence for people.

People told us they felt the service listened to them and their relatives. One person told us "I think that this company is good. They're prepared to listen, and they provide the results that you want." This was mentioned by others we spoke with. They also told us how staff encouraged people to be as independent as possible when providing support to them. Comments included "I don't see very well these days, but they try and encourage me to do different things, which help me to be as independent as possible in these circumstances."

People told us the staff protected their privacy and dignity when carrying out personal care. They said, "The door is always closed in the bathroom when they (staff) are seeing to her personal care." "They respect my privacy and dignity. For example, they'll (staff) always ask permission before giving care. I feel listened to and they will go out of the way to help." People valued this.

People and their relatives described to us how staff had gone over and above their duty to support them. This included one staff member who "Walked up the hill through the snow to reach me, because she knew that I couldn't get up without her being there. No vehicles could get up the hill during those heavy snows. That's what I call going beyond the call of duty. They are good girls and I am grateful for what they do." Others told us how staff collected prescriptions for them and posted letters. Another person told us how a staff member had supported them to travel a nine and half hour round trip to see their son. This demonstrated the commitment of staff towards the people they supported.

## Is the service responsive?

### Our findings

People told us and documents verified that each person had received an assessment of their needs prior to care being provided. "The manager came to assess my wife's needs before the care started. This was a full assessment, which took about two hours." "There was an initial lengthy assessment at home, when my own needs and the accommodation needs of the carers were assessed. My neighbour came along to this assessment as well as my daughter". From this information a care plan and risk assessments had been completed. People told us a copy of this was kept in their homes.

Care plans were task focussed and not wholly person centred. For example, there were details relating to people's physical welfare and schedules of care but little information related to people's health conditions and how these impacted upon them physically and mentally. It was important for staff to understand the implications for people of their medical histories, to ensure they maintained good health. In addition, staff needed to be aware of symptoms related to people's state of health that could be having an adverse effect on their wellbeing. This would enable staff to ensure care was appropriate and safe.

There were no documents related to how staff should manage the risks related to the conditions. For example, one person had a health condition and was supported by external professionals. The evening before our visit, there had been a problem with a piece of equipment, which meant the person was at risk. The alarm had been activated on the equipment to alert the person. There was nothing in the care plan to advise staff on the action to take. The staff member on duty the day of our visit had disconnected the equipment. We were later told by senior staff they should not have touched the equipment. This incident had not been reported to the senior staff. Without this information being shared with senior staff the care plan could not be updated or revised.

Some tasks were not clearly described, for example one person's care plan stated, "Attach night bag to convene". There were no clear instructions as to how to do this or the person's preference about how this should be done. Other people's health needs included stoma care (A stoma is an opening on the surface of the abdomen) epilepsy, diabetes, Parenteral nutrition, (Intravenous feeding, is a method of getting nutrition into a body through veins. The person was supported by an external professional with this) amongst others. There was a lack of documentation about how people wished to be supported with these conditions and a lack of information in the care plans about what staff should do if things went wrong.

The provider was supporting people with palliative care, and end of life care. Some people told us they had a Do Not Attempt Resuscitation (DNAR) form in place. However, they told us there were no care plans in place. Comments included "There is an end of life plan, which has been organised with the GP, but it doesn't form part of the care plan"." I know there is a DNAR on the care plan, but that's as far as any end of life planning goes." A person's computerised care plan stated they were to have palliative care in place from June 2018 but no updates had been made to the care plan.

The PIR stated "We also employ an end of life care specialist who has many years of experience working for a hospice at home. She works with many of our clients who are in the end of life situation and we have

recently developed a policy which ensures that our carers and other professionals who visit clients are well aware if a client has a DNAR notice." We did not see any formalised end of life care plans. Without this the provider could not be certain they would be providing care for people in line with their preferences and choices for their end of life care.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a complaints policy and procedure; and complaints log. We reviewed the four complaints recorded in the log since our last inspection in December 2016. Each one had been dealt with and where appropriate apologies had been extended to the complainant. Action had been taken to satisfactorily address the complaint.

Not all staff knew how to deal with a complaint. One member of staff told us if the complaint was made to them about another staff member they would "Do nothing." Staff had not received training in dealing with complaints.

People we spoke with told us "I feel confident about raising any concerns, and although there is a complaints' procedure on the file with the care plan, there has never been need to use it." "There have been no major concerns, but if there were, we would ring the office." Feedback from people's relatives and friends through the questionnaires highlighted some concerns about people's experiences of making complaints. One relative told us that when they had given feedback concerns to the service, they (provider) had appeared very defensive in their response. Another suggested management required training in responding appropriately with complaints.

We recommend that the service seek advice and guidance from a reputable source, about the management of and learning from complaints.

The provider had received numerous compliments, too many for us to count and review. These reflected people's gratitude for the care they received and the service provided.

## Is the service well-led?

### Our findings

We received mixed responses from people and their families about the quality of the management of the service. Some people told us "The Company seems to be well led". "Yes, I think the service is well led. The carers seem to be supported by their managers." "There's been a big turnover of managers over the past two years.... some current managers don't seem to know the area, or the travel requirements. This can put undue pressure on the carers." Feedback from our questionnaires was also mixed about the management. References were made to the weakness of some of the managers stating their concerns about the lack of oversight of the performance of staff and the lack of training staff appear to receive.

We had concerns about the management of the service. Training was not provided in all the areas staff required. Only one subject of moving and handling was deemed mandatory. Although induction training had been provided and was reportedly reflecting the Care Certificate, staff had not been observed on each of the standards to ascertain their competency.

Spot checks on staff administering medicines were not taking place to ensure they were competent. Those staff that we were told were responsible for assessing staff competence did not have up to date training in administering medicines.

The lack of oversight of the service meant the systems used for the recruitment of staff were not always safe. A lack of understanding by the management and staff in the service around the MCA and the code of practice meant that people's consent had not always been considered. Staff had not assessed people's capacity and there was no documentary evidence of them acting in people's best interest. Without this we could not be assured people's human rights were being protected.

There was a lack of training for staff in areas such as equality and diversity, safeguarding people, MCA, medicines administration; the Accessible Information Standards amongst others. Specialist training in areas such as diabetes, epilepsy and stoma care was not available to all staff who cared for people with these needs. Support for staff through supervision, spot checks and appraisals were not taking place in line with the provider's policy.

Care plans and risk assessments lacked important information. For example, the risks related to health conditions and the environment. Environmental risks had been considered by the provider; however, no mitigation had taken place as a result of identifying the risk. For example, in one person's records it stated the house had "frayed electrical wires...unprotected fires...obstacles such as frayed rugs...unsafe stairs...poor lighting and poor storage of hazardous materials." The risks were assessed as "low" and "medium". The provider has a duty of care to ensure the health and safety of their staff. There was no evidence any action had been taken to ensure this had happened.

Information was not person centred and the detail of information held about people was inconsistently recorded. For example, some people had more comprehensive information than others. People's likes, dislikes, preferences, personal interest and hobbies were not always recorded in care plans and end of life

care plans were not in place. Records regarding medicines were not always up to date and accurate. Overall, records were not effective.

Providers are expected to comply with the duty of candour statutory requirement. This regulation requires providers to be open and transparent with people who use services and/or their legal representative when things go wrong. It is also a requirement that providers must inform people about the incident, provide reasonable support, truthful information and an apology.

The regulation applies to registered persons when they are carrying on a regulated activity. When the registered manager was asked they were not familiar with the requirements of the duty of candour and were not able to clearly explain their legal obligations in the duty of candour process. Later in the visit, the registered manager returned to us and informed us they did not have a policy or procedure in relation to the duty of candour, and would instead use the regulation itself to provide guidance. This did not provide us with an assurance, systems would be put in place to ensure staff would be supported to understand their responsibilities with regards to the duty of candour regulation.

We were told by the registered manager they hadn't completed any audits apart from the medicines audits. The registered manager felt medicines audits need only be recorded when inexperienced staff were carrying out spot checks. He stated he did not believe there had been any medicine errors since the last inspection. However, there were five medicines errors raised as safeguarding concerns since February 2017. Due to the lack of quality assurance tools, the provider was not able to drive forward improvements in the same way they would if they had reviewed the service and its different components.

The General Data Protection Regulation (GDPR) became law in May 2018. The regulation is a new way of governing the privacy and security of personal data laid down by the European Commission. This means information related to individuals must be stored securely and individuals can ask for information to be deleted. The service had considered the GDPR but had taken no effective action. For example, they had written to staff and people using the service, but had not given a full explanation of people's rights under the new legislation. They had also not risk assessed their own processes in relation to data sharing. For example, we were told by staff, people's care plans and staff rosters which included people's personal details were sent by email to staff's personal phones and computers. The provider could not be certain of the security of this information. This is not in line with GDPR.

During our visit, we found two dosset boxes containing medicines. These belonged to a person who was using the service. The information on each of the boxes included personal data including their name, address and telephone number and the information related to the medicines they received. We asked the registered manager about why these had been left in the training room. They told us they were unaware of them and would investigate. This was another example of how data within the service was not protected.

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

On our arrival at the inspection we were told by the provider they had gone through a difficult 12 months. This was because they had previously employed two managing directors, both had proved "Unable to deal with complexities of running a domiciliary care organisation." At the time of this inspection the provider had a new managing director who had commenced employment on 1 May 2018. They were optimistic the managing director "Was in the process of rectifying many of the problems which had occurred during the last 12 months."

We were shown minutes of a meeting held between the provider and the managing director dated 5 June 2018. The meeting set objective in the immediate, medium and long term. It was noted one of the immediate objectives was for the managing director to become familiar with all aspects of the requirements for CQC and act where needed. The long-term goal was for the managing director to have full responsibility for all aspects of the business including compliance by April 2019. We were reassured the provider was taking a view of the future development of the service.

The service obtained feedback via an external research company. This was carried out in 2017. Mostly the feedback was positive but the researchers commented "In 2015 client satisfaction with Universal Care reached an all-time high and whilst the picture has waned somewhat in the 2017, the overall picture remains positive." The registered manager told us they believed the service had improved since we last inspected in 2016. We fed back our findings at the end of the inspection to the registered manager. They accepted some of the areas we had identified as requiring improvement but not all. Whilst we found a willingness to provide a good service to people, this was hampered by a weak framework of accountability. A lack of understanding of the value of monitoring performance has led to a failure in improvements to the service since our last inspection in December 2016.

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	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>The provider failed to ensure that the care and treatment of service users was appropriate, met their needs, and reflected their preferences</p> <p>Regulation 9 (1) (a) (b) (c) (2) (3) (a) (b) (c) (d) (e) (f) (g) (h) (i) (4) (5)</p>
Personal care	<p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>The provider failed to ensure care and treatment of service users was only provided with the consent of the relevant person.11 (1) (2) (3)</p>
Personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider 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 is reasonably practicable to mitigate any such risks. The provider failed to ensure the proper and safe management of medicines. 12 (1) (2) (a) (b) (g)</p>
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p>

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. 17 (1) (2) (a) (b) (c) (e) (f)

### Regulated activity

Personal care

### Regulation

Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

The provider had failed to ensure they had provided information required in Schedule 3, of the regulation. Insufficient checks had been made to ensure safety of employee. 19 (2) (a) (b) (3) (a) (b) .

### Regulated activity

Personal care

### Regulation

Regulation 18 HSCA RA Regulations 2014 Staffing

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.18 (2) (a)