Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Inspection Report on

Unite Care Group Ltd

Regus House
Malthouse Avenue
Cardiff Gate Business Park
Cardiff
CF23 8RU

Date Inspection Completed

15 December 2021

About Unite Care Group Ltd

Type of care provided	Domiciliary Support Service
Registered Provider	Unite Care Group Ltd
Registered places	0
Language of the service	English
Previous Care Inspectorate Wales inspection	6 January 2021
Does this service provide the Welsh Language active offer?	No. This is a service that does not provide an 'Active Offer' of the Welsh language. It does not anticipate, identify or meet the Welsh language needs of people /children who use, or intend to use their service.

Summary

Unite Care is a domiciliary support service currently operating in the Cardiff region. The responsible individual (RI) is Hannah Beasant-Simpson. The service is being managed by the operational manager, due to a vacant manager post. The operational manager is qualified and oversees day-to-day operations. The inspection found poor outcomes and quality of care for people. There is a significant lack of oversight and governance of service delivery. The provider has failed to implement effective whistle-blowing and safeguarding policies and procedures to safeguard individuals. There is a lack of managerial oversight to identify problems and maintain the safety and well-being of people. The impact on people due to these failings could be major. Most people told us the practice of care workers is positive and they are treated with dignity and respect.

The service has not addressed three areas for improvement found at the last inspection. At this inspection, we also found additional failings in multiple areas. The service needs to take immediate action to address this.

Well-being

People are not kept as safe as possible, from harm and abuse, because the provider has not enabled the manager and workforce to identify and report problems properly. There is a lack of manager oversight of safeguarding allegations. The service does not appropriately record, investigate and analyse safeguarding allegations in order to implement actions and learn lessons to prevent further events. Unite Care do not have a true and accurate understanding of the scale of concerns and safeguarding complaints they receive. We found discrepancies in safeguarding information held by the service compared to records held by the Safeguarding Team. Unite Care have also delayed sharing safeguarding information on more than one occasion.

We have received some unfavourable feedback from the workforce and other stakeholders, about the way the service is managed and how this impacts on the well-being of people. We found evidence of poor quality of care being delivered to people, which has had an impact on people's well-being.

Unite care have a safeguarding and whistle-blowing policy in place which requires updating to comply with current guidance. The policy is ineffectual and it does not give reference to how staff will be protected and supported through the process. We saw instances where this had been the case for people raising concerns. Staff lack awareness of what to do when reporting harm or abuse. This means staff may not realise they have the right to be protected, by their employer, from possible repercussions of reporting acts of abuse or neglect. This lack of understanding may inhibit staff from coming forward to report. The lack of knowledge could lead to people at risk not being safeguarded quickly and effectively.

People cannot be confident they are cared for by a service which completes robust recruitment checks to keep people as safe as possible. Security checks for staff requires improvement. Staff DBS (Disclosure and Barring Service), recruitment checks and employee risk assessments are not robust enough. We found records did not evidence DBS checks and risk assessments for employees where required. A high proportion of care workers are not registered with Social Care Wales, although it is accepted that currently there are some challenges around the registration of the workforce during the pandemic.

We expect the provider to take immediate actions to address safeguarding matters and we will follow this up at the next early inspection.

Care and Support

Some people have told us they are not happy with the care and support they receive due to the service being disorganised. Care workers do not always arrive on time and some people have not received care and support due to missed calls. Feedback from people about the practice of individual care workers is mostly positive. Most people feel care workers treat them with dignity and respect.

People cannot be confident their care workers will have all the information they need before carrying out care and support to them. The provider fails to identify that important information is missing. We found documentation lacked necessary assessments and personal plans, despite care being delivered. There is no arrangement in place for safe management of medication, no clear records for the administration of medication and the provider's medication policies and procedures are ineffectual. Late, missed and early calls has an impact on people receiving their medication on time. People cannot be confident that they will be given medication by well-informed care workers.

Personal plans are not regularly reviewed and most people and their representatives don't have access to them. Care and support files lack evidence of regular consultation with people and professionals. When people's changing needs are not appropriately met, people cannot be confident their care workers will have up to date information on knowing how best to support them. Daily recordings are basic, task centred and require improvement to focus on the person.

People cannot be assured they will receive care that is well monitored and organised with accurate and up to date records. We were unable to access care records including call end times for people, therefore we could not be confident that care workers stay the full duration of a care call. Some people and some staff have told us that care workers do not stay the full duration of a visit. Some people have said they receive calls that are too early, late or missed completely, meaning they have gone without care and support. We have been made aware of some individuals who have gone without access to food, fluid, pressure relief, personal care, and have been left in bed for a longer period of time, impacting on their well-being.

People cannot be confident they will be cared for by care workers that are suitably trained, monitored and supervised. Staff supervisions and training are not happening frequently enough and the provider fails to check staff knowledge and practices.

People tell us that care workers always wear 'Personal Protective Equipment' (PPE) appropriately. However, there is no evidence that care workers are suitably trained in infection control.

Leadership and Management

People do not benefit from a service which promotes the well-being and development of care workers. Most care workers we spoke too told us they have not had recent training and believe communication from management requires improvement. Other care workers have told us that management are approachable and supportive.

People cannot be assured there are effective governance arrangements in place to protect and promote their safety, health and well-being because there is a lack of managerial oversight at the service. We found missing records and a lack of oversight of safeguarding, care delivery, medication, accident and incidents and complaints. People who raised concerns with us, told us they felt their complaints were not acknowledged by management. We found complaints are not recorded properly, analysed or always responded to appropriately to enable people to feel listened too.

The RI has not completed quality of care checks, demonstrating a lack of insight into the performance of the service. The RI has not fully tested evidence of care delivery and has failed to identify the areas that require oversight, improvement and immediate action. There is a lack of quality and audit systems to gather and analyse information, with opportunities for lessons to be learnt.

Unite Care have secured improvements since the last inspection in three of six areas of previously identified failings. They have updated service agreements, a written guide and a complete full employment history for staff. Unite Care arrange monthly senior management team meetings. This is positive, but further improvements are needed when responding to concerns raised by staff about the well-being of people. Since the last inspection, Unite Care has three areas where progress and change has not been effected. Unite Care continues to fail to ensure that care workers are offered a fixed contract instead of a zero hours contract. This increases the risk of high turnover of care workers resulting in lack of consistency in care workers for people. There continues to be insufficient travel time for care workers which impacts on care workers arriving on time for people. There are some arrangements in place for obtaining the views of people, but this information should be considered to inform the future shaping of the service. This opportunity should also be given to seek the views of relatives, staff and stakeholders.

Environment

The quality of the environment is not a theme which is applicable to domiciliary support service. However, the service operates from an office with good facilities for staff. The building is secure and there are locked cabinets for the storage of confidential information. There are rooms available to hold meetings with the care staff team.

Summary of Non-Compliance	
Status	**What each means**
New	This non-compliance was identified at this inspection.
Reviewed	Compliance was reviewed at this inspection and was not achieved. The target date for compliance is in the future and will be tested at next inspection.
Not Achieved	Compliance was tested at this inspection and was not achieved.
Achieved	Compliance was tested at this inspection and was achieved.

We respond to non-compliance with regulations where poor outcomes for people, and / or risk to people's well-being are identified by issuing Priority Action Notice (s).

The provider must take immediate steps to address this and make improvements. Where providers fail to take priority action by the target date we may escalate the matter to an Improvement and Enforcement Panel.

Priority Action Notice(s)		
Regulation	Summary	Status
6	The service provider has failed to ensure that the service is provided with sufficient care, competence and skill, having regard to the statement of purpose.	New
21	The service provider does not ensure that care and support is provided in accordance with assessed needs with a focus on the well-being and personal outcomes of people. This is due to missing records for care workers to understand how best to support people, late and early care calls and the lack of managerial oversight of care delivery. The service provider also fails to ensure care and support is delivered in a way which protects, promotes and maintains the safety of individuals. There is a lack of arrangement in place for monitoring people's safety and notifying other professionals at the earliest opportunity.	New
26	The service provider does not deliver a service in a way which ensures that individuals are safe and are	New

	protected from abuse, neglect and improper treatment.	
58	The provider does not have safe policies and procedures in place for administrating medication to people.	New
42	Regulation 42(1): Employment contracts: Care workers who elect to remain on a non-guaranteed hours contract must be a given a further choice of alternative contractual arrangements three months after their last choice was made.	Not Achieved
41	Delineation of travel time: Regulation 41 (3)(a)-(b)- The service provider must prepare a schedule of visits for care workers with sufficient travel time allocated to travel in between visits having regard to matters specified under Regulations 41 (3)(a)-(b)	Not Achieved
76	Engagement with individuals and others: Regulation 76 (1)(a)(b)(c)(d)(e) – The responsible individual must put suitable arrangements in place for obtaining the views	Not Achieved

Where we find non-compliance with regulations but no immediate or significant risk for people using the service is identified we highlight these as Areas for Improvement.

We expect the provider to take action to rectify this and we will follow this up at the next inspection. Where the provider has failed to make the necessary improvements we will escalate the matter by issuing a Priority Action Notice.

Area(s) for Improvement		
Regulation	Summary	Status
N/A	No non-compliance of this type was identified at this inspection	N/A
35	Regulation 35(2)(d): Recruitment: There must be a full, continuous employment history with a written explanation for any gaps.	Achieved
19	Regulations 19(2)(a) & 19(3)(b): Written guide: Must include information about the availability and access to advocacy services and be reviewed at least	Achieved

	annually.	
20	Service agreement: Regulation 20 (1) – the service provider must ensure that every individual is given a signed copy of any agreement	Achieved
	Personal plan: Regulation 15 (1)(c) – the steps which will be taken to mitigate any identified risks to the individual's well-being – ensure arrangements in place to investigate accident and incidents to ensure appropriate measures have been taken to safeguard the individual	Achieved
	Notifications 60: Regulation 60 (1), (3),(4),(5) – The service provider must notify the service regulator of any events specified in schedule 3	Achieved

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