London Care Limited

Custom Care (Stoke)

Inspection report

Unit 2 & 3 Burslem Enterprise Centre
Moorland Road, Burslem
Stoke On Trent
Staffordshire
ST6 1JQ

Tel: 01782839023
Website: www.customcare.co.uk

Date of inspection visit:
22 September 2016

Date of publication:
09 September 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.
If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

We completed an announced inspection at Custom Care (Stoke) on 22 September 2016. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available to speak with us.

The service provides personal care to people who live in their own homes. At the time of the inspection there were 146 people using the service. There was a branch manager in place who was going through the process of registering with us. 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.

At the last inspection on 16 March 2016, we found the provider was not meeting the required standards. At this inspection we needed to check whether the provider had met the requirements of the warning notices which we had issued, following the inspection. The warning notices were issued in respect of Regulation 11 (Need for consent), Regulation 16 (Receiving and acting on complaints) and Regulation 17 (Good Governance) of the Health and Social Care Act 2008 and associated regulations 2014. This was because we had concerns that people were not always receiving their care as planned due to the way call times were managed. We also had concerns that medicine recordings were not always accurate. The provider was not always checking if relatives had the legal powers to consent to their relations care. We had further concerns that the provider did not have a process for receiving and handling complaints and that the provider's systems to monitor the quality of the service were ineffective. We undertook this inspection to check that

they had followed their action plan and to confirm that they now met the legal requirements. People were still not receiving their care at the agreed times due to the way call times were managed, and due to insufficient staff. People's risks were not assessed effectively to keep them safe. People were at risk of harm because care records did not always match the support that staff told us people needed to keep them safe.

Medicines were not managed safely as we could not be assured that people were receiving their medicines as prescribed, and plans were not in place for people who sometimes refused their medicines.

People's risks to their health and well-being were not consistently identified, managed and reviewed and people did not always receive their planned care. This meant people's safety, health and wellbeing was not consistently promoted.

The principles of the Mental Capacity Act 2005 (MCA) were not followed as records we viewed did not contain evidence that relatives were legally able to consent to care on behalf of their relations. This meant we could not be assured that decisions were always made in people's best interests.

We found the systems in place to assess and monitor the quality of the service were not effective. Where concerns were raised at the previous inspection there had been limited action taken to mitigate the risks for people who used the service. This meant that poor care was not being identified and rectified by the provider.

People told us that staff treated them in a caring way and respected their dignity when they provided support. Staff gave people choices in how they wanted their care provided. However, staff did not always have the information needed to provide the level of support required.

Staff had received training and an induction before they provided care, and were receiving supervisions. Staff understood their responsibilities to protect people from abuse and were able to explain the actions they would take if abuse was suspected.

The provider had a system in place to handle and respond to complaints that had been made by people who used the service and their relatives, however further improvement was needed to improve this process to ensure these were fully investigated.

People were referred to health and social care professionals where concerns had been raised by staff or if someone had become unwell.

We identified continued breaches and additional new 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?

Inadequate

The service was not safe.

People were not receiving their care as planned and there were not enough staff to support people at the times the agreed times.

We could not be assured that people got their prescribed medicines at the time they needed them.

People's risks had not been assessed or monitored effectively to keep people safe.

Staff knew how to recognise and report suspected abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider did not check that people's relatives were legally able to make decisions on their behalf in line with the Mental Capacity Act 2005.

People's nutritional needs were met and they were supported to maintain a healthy diet. People received health care support when they needed it.

Staff received training and support to enable them to fulfil their role effectively.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not receiving their care when they needed it.

People told us that staff treated them in a kind and caring way.

People told us they were treated with dignity and respect when staff provided support.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

We found that people's preferences in regards to carers had not been considered.

Staff knew people and their support needs well, however, the records did not reflect what staff told us and had not been updated when people's needs had changed.

Is the service well-led?

Inadequate

The service was not well-led.

We found the systems in place to assess and monitor the quality of the service were not effective. Some of the concerns we raised at the previous inspection had been identified, but no action had been taken to mitigate the risks for people who used the service.

Records about people's care were not accurate and up to date.

Custom Care (Stoke)

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.'

This inspection took place on 22 September 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available to speak with us.

This inspection was undertaken by two inspectors and an 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.

We spoke with 17 people who used the service and four relatives. We spoke with the manager, the regional manager, the managing director and six care staff and the commissioners for the service.

We looked at the care records for seven people who used the service. This included their daily and medicines records. We did this to ensure that they were accurate, clear and comprehensive.

We looked at the systems the provider had in place to monitor the quality of service. We did this to ensure there was a continuous drive for improvement.

Inadequate

Is the service safe?

Our findings

At our previous inspection we had concerns that staff did not always arrive at the agreed time or stay for the correct amount of time. At this inspection we saw that these issues were still on-going and people were not receiving their care as planned and were at risk of not receiving support when they required it. People we spoke with told us that staff didn't always turn up on time. One person told us, "You can tell when they are running late as the staff always seems to be rushing. They come early or late, I don't really like it when they are early, but it's when they have other people to see to, it's me that suffers really".
We saw rotas that showed calls were planned at the same time for different people who used the service and also saw the actual times staff arrived at the calls. Travel time between calls was not included and staff were regularly late getting to people. We saw that staff had arrived one hour earlier or later than the call time requested on occasions. One person told us, "If they are late, you just have to wait until they get to you, and if they're late it means I don't have a shower as I'm already dressed by the time they get to me". This meant that staff were not able get to those people to deliver their care at the agreed time of their package.
People and their relatives also told us that there was sometimes a lack of consistency with staff. One person told us, "They send different carers and you have to keep telling them what you want doing and where things are and it just gets annoying" And a relative told us, "We used to have a regular carer, and then they changed them as our call was clashing with another call, we're getting used to them but we preferred the other carer". These issues had been identified during our last inspection and we spoke with the manager and management team who acknowledged that this was an on going problem. They told us they were in the process of recruiting more staff and were working with the commissioners of the service to try sort out the way packages of care were agreed.

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

People's risks were not always assessed and planned for to protect their safety and wellbeing. Some people had identified risks but no risk assessments or care plans referring to these risks were contained in their care records. Care records showed that staff did not effectively manage these risks as they frequently reoccurred. For example, one person displayed behaviours that may challenge and on occasions had assaulted staff. One person frequently displayed episodes of inappropriate verbal behaviour towards female members of staff, and another person had been refusing medication with a particular staff member but the staff member was still on this person's package of care for the coming weeks. All of these issues had been highlighted to the management team by staff members, but no action had been taken to mitigate the risk of this continuing. This meant that people, and staff supporting them were at risk of harm due to measures not being in place to help prevent the risk occurring again.
People told us that staff supported them with their medicines and that they got their medicines when they needed them. One relative told us, "My relative has health problems so the staff come and give him his medication". Staff we spoke with told us that they felt competent to support people with their medicines. One staff member said, "I've just done a refresher course for medication and we have regular spot checks to make sure we are doing things properly". However, we saw records when people had sometimes refused their medication. There were no protocols in place to try to limit these instances happening again, or

guidance when staff needed to be escalate issues to the manager . There were several missed entries on medicine administration records (MAR), some of these missed entries were for medicines such as Warfarin that can have a significant effect on a person's health if doses are missed. There were crosses entered onto MAR sheets with no explanation for them. This meant we could not be assured people were getting their medicines as prescribed.. This meant people were at risk of their medical conditions deteriorating due to missed medicines as staff did not keep reliable records of the medicines they had administered, or consistently report when people had missed their medicines.

The above issues constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with staff about safeguarding and they all understood the safeguarding adult's procedures and were able to demonstrate that they understood the types of abuse that could occur, how to recognise these and how to report their concerns. One staff member said, "I've had to report a safeguarding incident before, I rang into the office to speak to the manager and reported it, they passed it onto the local authority as that's who deals with these issues. It's important that you report any issues straight away, even at weekends we have a system in place so things can get dealt with". Another staff member told us, "We have training about how to report any safeguarding incidents" We saw that local safeguarding adult's procedures had been followed when required and that suspected abuse was reported to the local authority and investigated when needed. We saw that where safeguarding concerns had been reported, the provider had raised these with the local authority, investigated the issue and put plans in place to try to prevent the incident occurring again.

Staff told us and records confirmed that safe recruitment practices were followed. Staff files included application forms, records of an interview and appropriate references. We also saw records that confirmed that criminal records checks had been made with the Disclosure and Barring Service (DBS) to make sure staff were suitable and safe to work with people who used the service. The DBS is a national agency that keeps records of criminal convictions.

Requires Improvement

Is the service effective?

Our findings

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.
At our previous inspection we found that the service did not always act in accordance with the MCA. This was a breach of Regulation 11 of The Health and social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the issues identified at our previous inspection were still on-going. We saw in some people's care records that relatives had signed consent forms on the person's behalf. We asked the manager if these relatives had legal responsibility for making decisions on their relations behalf and were told they could not be certain as no evidence of this had been sought. This meant people were at risk of their rights not being respected as the correct consent was not being sought in relation to decision making.

This meant that the principles of the MCA were still not being followed and the service was still in breach of Regulation 11 of The Health and social Care Act 2008 (Regulated Activities) Regulations 2014

People we spoke with told us that staff offered them choices at meal times and they were supported to eat and drink to enable them to maintain their health. One person told us, "They always ask me what I want doing, or what I want to eat, they don't just presume anything". They always ask me if I want a drink making before they leave". We saw that care plans had details of the level of support people required with preparing meals and also details of where people may need prompting to eat due to their dementia.

The majority of people and relatives we spoke with told us that staff had the skills to support people effectively. One person said, "Yes, they do know what they're doing, and they do mention sometimes that they are having training". However, another person said, "The regular ones are very good with everything, they've helped [relative] improve a lot but sometimes the new ones aren't as good".

Staff we spoke with said they had received training as part of their induction and also had on-going training. One member of staff told us, "I've recently just completed some of my yearly refresher training courses; these were done face to face in the office so we got to practice what we were being taught". Another staff member told us, "I've had training in the MCA and know that you should always assume someone has capacity unless they have been assessed as not having capacity in those areas". Staff told us and records showed that they received supervision and regular spot checks. One staff member said, "We have supervisions, and these are much better now as they are aimed at specific topics such as safeguarding or medication. They're sort of like a quiz and test your knowledge. We also have them if something is picked up during a spot check that we might need to improve on".

We saw that people were supported to access healthcare professionals and to enable them to maintain good health. One person told us, "They get the doctor for me if I'm not well, they're good like that". Staff told

us that on occasion they have had to contact health professionals for people they support as they were worried about them. One staff member said, "I always ring the district nurses if I see sore skin or if a dressing has come off, and also have rung 999 when a person has been unwell".

Requires Improvement

Is the service caring?

Our findings

At our last inspection we had concerns regarding people not always getting the support they needed at the times they needed. At this inspection we found that people were still not receiving a caring service as people were scheduled in to receive support at the same time as other people. This meant that staff were often late arriving, or did not have the correct amount of time to spend supporting people. People told us that they sometimes got anxious if they didn't know what time staff were coming or which staff they would be getting. One person said, "We are ok with them, but sometimes they are late and it's not nice". A member of staff told us, "We don't have time to sit and talk, and sometimes that's all people want". This meant people did not always receive care that made them feel they were important.

People told us they were happy with the way the staff supported them and said staff were kind and caring. One person said, "The carers are very good, they are all really nice". Another person said, "I'm happy with how they look after me". Relatives told us that the staff always treated people in a kind way and they were happy with the way staff cared for their relative. One relative said, "They help my [relative] very well, they are very happy with them".

People and their relatives told us that they were treated with dignity and respect when staff were supporting them. One relative said, "The staff always talk to them while helping them in the shower and when they are helping them to get dressed, as it makes it less of an embarrassing situation". One staff member told us, "I try and talk to people about something we have in common to engage with them".

Staff we spoke with were able to tell us that they knew people well and enjoyed providing support to people. One member of staff told us, "I love my job, I have consistent people that I look after and have gotten to know them and their preferences very well over the years and I like knowing that I make a difference to them". Another staff member said, "I look after people how I would like my grandparents to be looked after". Staff were also able to tell us what kinds of techniques they used to help them support people who sometimes could be resistive to care. One staff member said, "Sometimes I have people that don't want to have a shower or bath, so I'll ask them if they want a wash instead and gently try to explain why keeping their skin clean is important. I might leave it 10 minutes and see if they've changed their minds".

Requires Improvement

Is the service responsive?

Our findings

People had agreed the times of their care calls prior to the service starting at a pre assessment meeting. Care plans had been drawn up and agreed by the person and the provider. However we found that people's agreed call times were not being met and care was not being delivered as planned. We saw that where people had expressed preferences regarding staff members that they wished to be supported by, these had not been recognised. For example one relative told us, "My [relative] prefers the lady carers as they are more chatty than the men, they just get on with it. I understand that more men are applying for jobs now, but they would prefer a woman. I have told them they prefer the ladies but we still get men". A member of staff told us that there is a person that they support that doesn't like male staff, and despite this being raised as an issue men were still being allocated to support the person. This meant that people were receiving task focused care that was not personalised to their preferences of gender or personalities of staff.
This meant that people's preferences and views were not being respected. This constitutes a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with knew people's preferences and were able to tell us how people liked to be supported to maintain their independence. However, we found that improvements were needed as the care plans we viewed did not contain detailed information for staff to be able to support people correctly. We found that some daily notes were very hard to read due to poor handwriting and we could not see evidence that daily notes were audited for any issues that may have been overlooked by care staff. We found that one person's care plan had been audited and it stated that there were no changes required, however we found that the number of care calls in the care plan did not match the commissioners agreed plan of care. This meant there was a risk of people receiving inconsistent care because records did not contain up to date guidance for staff to follow.

At our last inspection we raised concerns that when people or their relatives raised a concern or complaint that these were not dealt with. At this inspection we saw that improvements had been made and the majority of complaints were being recorded, investigated and outcomes were being discussed with complainants. People and their relatives told us they knew how to complain if they needed to. One relative told us, "We got given a complaints policy that tells us what to do if we're not happy, and I can ring the office staff and they'll put me through to the manager if I need to raise an issue". Another relative we spoke with said, "We had complained about an issue and the staff in the office addressed it". We saw that where an issue had arisen with a staff member there had been a full investigation carried out, disciplinary action taken against the staff member and an outcome letter sent to the complainant detailing the steps that had been taken to rectify the situation. However further improvements were needed to ensure that all complaints were investigated fully to identify the root cause . We found one issue where the cause was found to be carer error, whereas on further analysis it was communication from the branch that had caused the issue.

Inadequate

Is the service well-led?

Our findings

At our previous inspection we found the provider was in breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the systems they had in place to ensure a good quality service was delivered were ineffective. At this inspection we found that people were at continued risk of not receiving good quality care due to the way call times were managed, which meant that staff arrived late to calls and carers were not able to spend the allotted time providing support to people.

We found that care records were out of date and did not correspond with the care that was being provided. For example; staff knew people's risks and were able to explain the level of support required, but the records did not always show how people's risks should be managed. We found that people's care records had not been reviewed regularly or when people's needs had
changed. We saw the provider did not have an effective system in place to check care records regularly to ensure they were up to date. For example, we found one care plan that had been recently audited stated they were no changes required; however the person was receiving a different number of visits per day. This meant that service users were at risk of inconsistent care because the provider did not keep an accurate and complete record of people's care needs.

Systems in place to monitor medicines were not effective. During the inspection we found that the Medication Administration Records (MAR) contained gaps in recording, some of these gaps were for critical medicines such as Warfarin that can have a significant effect on a person's health if doses are missed. There was also unclear information for staff to follow regarding people that sometimes refuse to take their medication. This meant people were at risk of their medical conditions deteriorating due to missed medicines as staff did not keep reliable records of the medicines they had administered, or consistently report when people had missed their medicines. MAR records that had been audited did not pick up the issues that were highlighted during our inspection. These issues meant that the medicines audit was ineffective in addressing areas of risk to people in respect of the safe management of their medicines. We found other quality assurance processes did not always identify the root cause of the issue therefore the provider could not effectively put plans into place to mitigate the risk of the issues occurring again. This meant audits were ineffective in driving improvements to ensure people received person centred care based on accurate and up to date information about their needs.

We found the manager had not acted in accordance with the Mental Capacity Act 2005 as people's ability to consent to their care had not been taken into account. People's relatives were consenting on their behalf and the manager had not recognised that this may put people at risk of harm. This meant that the manager was unaware of their responsibilities to protect people from the risk of inappropriate and unsafe care.

We were provided with an action plan following our previous inspection detailing the actions that would be completed to make improvements to the service provided. Although we saw some progress had been made, actions were on-going since April 2016. We saw that an action regarding complaint handling stated this had been actioned and that all complaints would be logged on the providers internal electronic management system to ensure the correct process was followed. However, we saw instances where complaints had been

logged onto the system but no further detail about this had been added and office staff had to find the information from files in the office. We also saw instances where full details of accidents and incidents had not been added to the system. This meant that the system to assess, manage and make improvements to the quality and safety of the service were not effective. During our last inspection there was a breach in Regulation 11 (need for consent) based on care plans containing uncorroborated information around family members authority to make decisions on behalf of their relative. The provider stated on their action plan that new paperwork had been introduced to ensure correct information was captured. However, during this inspection we found files that stated that family members had the legal right to make decisions on behalf of their relative that the provider could not evidence.

All of the above issues meant the provider did not have effective systems in place to ensure that the quality of service people received was assessed and monitored. The provider did not maintain accurate records to ensure that staff had sufficient guidance available to support people effectively and safely. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A new manager had been appointed who was in the process of registering with us. We were told by the manager and management team that they were currently looking at the actions that were needed to improve the service but these had not been implemented at the time of the inspection. We found that the management of the service had not been stable for some time and the regional manager had only recently been employed at the service. The managing director told us that they had started to implement new processes but these had not been implemented at the time of the inspection. This meant we were unable to assess whether the recent change in the management structure would be sustained.

We received positive comments about the manager at the service. Some staff told us that they felt able to approach the manager if they had any concerns. One staff member said, "Yes, she's only been here a short time but I think I could go to the manager with any issues. There's already been a lot of changes happening since she has been in post". And another staff member said, "Yes, the new manager is very approachable, issues are being dealt with quicker and we are getting more training and better supervisions".

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's preferences in regards to staff not respected. People's agreed call times were not being adhered to and care was not delivered as planned.

The enforcement action we took:

We issued a Notice of Proposal to remove the location

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent MCA principles not being followed, and meant people were at risk of their rights not being respected as the correct consent was not being sought in relation to decision making.

The enforcement action we took:

We issued a Notice of Proposal to remove the location

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's risks were not assessed and planned for.

The enforcement action we took:

We issued a Notice of Proposal to remove the location

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Ineffective audits, no registered manager, peoples risks not being managed.

The enforcement action we took:

We issued a Notice of Proposal to remove the location

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always arrive at the stated time, or stay for the agreed amount of time, meaning that people did not get their care as planned.

The enforcement action we took:

We issued a Notice of Proposal to remove the location