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:
16 March 2016

Date of publication:
24 May 2016

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?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 16 March 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.

The service provides personal care to people who live in their own homes. At the time of the inspection there were 161 people using the service.

There was a branch manager in place but they were not registered 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.

There was a lack of leadership at the service and although the provider was aware of many of the issues raised during the inspection, there was no one person clearly responsible for driving improvements. People remained unhappy with the service they received and the responses to their concerns, despite the provider having plans for improvement in place.

People told us that staff did not always arrive at the agreed time or stay for the stipulated amount of time. Some people felt that there were not enough staff to provide them with a consistent staff team.

When staff supported them, people told us they got their medicines when they needed them. However we saw that there were gaps in the recording of topical creams for people who required these which meant that people could not be assured that they had received their creams as prescribed.

Care staff knew how to recognise and report suspected abuse to senior staff members, however the manager told us that concerns reported over the weekend would wait until Monday before being reported to the local authority. This was not in line with local safeguarding adults' procedures and meant there was a risk that immediate concerns to people's safety and wellbeing may not be addressed.

We found that the principles of the Mental Capacity Act 2005 were not always followed to ensure that people's legal and human rights were respected and consent was not always sought from the relevant person.

People knew how to raise a concern or make a complaint but we found that people did not always receive satisfactory responses when they had done this. There was no effective system in place to receive, investigate and respond to complaints.

People told us they had been involved in the development of their care plans and the plans contained enough information for staff to be able to support them effectively. However, people were not always asked

for their preferences in relation to the gender of staff who supported them.

Effective systems for monitoring the quality and safety of the service provided were not in place.

Some people told us they were treated with kindness and compassion and valued the relationships with their regular staff. However, many people did not have a regular staff team and felt anxious that they did not know who would arrive to support them and when.

People told us that staff mostly treated them with respect and dignity and supported them to be as independent as they could be.

Safe recruitment practices were followed and the provider was in the process of recruiting more suitable staff. People's risks were assessed and monitored.

People told us that staff had the right skills to support them and we saw that staff had completed training and received supervision to support them in their roles. People were supported to eat and drink sufficient amounts and people were supported to access healthcare professionals when required.

We identified three 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?

Requires Improvement

The service was not consistently safe.

Staff did not always arrive at the agreed time or stay for the stipulated time and some people felt there were not enough staff to provide them with a consistent service. People told us they received their medicines as prescribed, however there were gaps in the recording of topical creams administration. Staff knew how to recognise and report abuse and people's risks were assessed and planned for.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The service did not always seek consent from the relevant person before providing care and the principles of the Mental Capacity Act 2005 were not always followed to ensure people's legal and human rights were respected. Staff received training and support to carry out their roles effectively and people were supported to eat and drink sufficient amounts. The service supported people to monitor their health and contacted professionals for support when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not always know who would be arriving to support them or what time they would arrive, this made some people feel anxious. People said they were treated with kindness and compassion and felt they had good relationships with their regular staff but not everyone had regular care staff and had the opportunity to build relationships with staff because they did not see them regularly. People told us that they were offered choices about their care and that staff respected their privacy and dignity. However, records did not show that people were always involved in developing their care plans and asked about their choices and preferences. People were encouraged to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive a satisfactory response when they made a complaint or raised a concern to the service. People were not asked for their preferences in relation to the gender of staff who supported them. People had individual care plans in place that reflected their needs and how they liked to receive their support.

Is the service well-led?

Inadequate

The service was not consistently well-led.

Effective systems were not in place to ensure that the quality and safety of the service was monitored and improvements acted upon. The provider was aware of many of the issues identified at the inspection though people remained unhappy with the service they received and there continued to be late and missed care calls. There was no one specifically responsible for driving improvements as there was no registered manager. People had mixed views about whether the management were approachable though staff mostly felt supported and were positive about changes taking place to make improvements.

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 16 March 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.

The inspection team consisted of two inspectors and two experts by experience who carried out interviews with people who used the service or their relatives via the telephone. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed 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 this information alongside information from the local authority and commissioners to help us plan our inspection.

We spoke with 21 people who used the service and 11 relatives. We also spoke with eight members of care staff, the branch manager, a clinical support manager and a managing director.

We looked at the care records of 14 people who used the service to see if they were up to date and reflected the care received. We also looked at six staff files, complaints records and other documents to help us see how care was being delivered, monitored and maintained.

Requires Improvement

Is the service safe?

Our findings

Some people we spoke with told us that staff did not always come at the agreed time or stay for the stipulated time. One person said, "They come whenever they can get here. Sometimes, it's a little frustrating, I'm kept waiting, sometimes for up to an hour or more." A relative said, "They should come at 9pm or just after but they've come much later." My relative lives alone, it's not safe them showing up so late." We saw records that showed that staff did not always complete visits at the times agreed by the commissioners of the service which could have a negative impact for people who require time specific care such as medication support or pressure area care. However, the manager told us that some people had requested to change the times of their visits though this was not always clearly recorded in their care records which meant it was difficult to know what planned times had been agreed by people who used the service.

People had mixed views about whether they had a consistent staff group to support them. One person said, "It's not often I get the same carers, particularly at night times it fluctuates. It makes me feel a little bit anxious because I'm not sure who will be coming into my home." Another person said, "In the week I have regular staff who I am settled with. At weekends different people are turning up who I don't know, I find that difficult." Staff told us they did not feel there were enough staff to consistently meet people's needs. One staff member said, "There's not enough, every day I get asked to cover extra calls, we need a few more staff." Another staff member said, "At the moment there's not enough staff, we get asked to cover a lot, it can be difficult." The managing director told us that there are contingency plans in place when staff are off sick which include trying to replace the staff member with another staff member who is familiar with the person. If this is not successful, office staff are trained to provide care to people and in extreme circumstances the provider would use staff from their other branches to cover calls when required. They told us that recruitment of staff was an ongoing process and that they were advertising to recruit additional staff. The provider used a tool to work out the numbers of staff required to deliver a safe service to people which looked at the number of support hours the service is commissioned to provide. Using this tool, the managing director told us that the service was currently slightly short of staff and they were aware of this and working to recruit more suitable staff.

Staff told us and we saw that safe recruitment practices were followed. This included requesting and checking references and Disclosure and Barring Service (DBS) checks for all staff to make sure that they were safe and suitable to work with the people who used the service. The DBS is a national agency that keeps records of criminal convictions.

People told us that staff helped them with their medicines and that they got their medicines when they needed them. One relative told us they were concerned that staff were arriving later and later and this was starting to affect their relative's medicines regime. However they told us this had recently improved. Staff we spoke with told us that they felt competent to support people with their medicines. One staff member said, "I've done medication training, it was good, it covered everything I needed to know. We only give medicines if it's in the person's care plan and we follow what is on the Medicines Administration Record (MAR)." We saw that guidance was in place for staff to follow when administering oral medicines to people. However, when people were prescribed topical creams, we saw that the guidance in place for staff was not clear. For

example, we saw 'apply creams' was noted in people's care plans but it was not clear where the cream should be applied or what the cream was used for. We saw there were some gaps on MAR charts when creams should have been applied. This meant people could not be assured that they had received their creams as prescribed.

Most of the people we spoke with told us they felt safe when they were supported by staff. One person said, "'Oh yes, definitely I feel safe with them." Staff had an understanding of safeguarding 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 to senior staff members. One staff member said, "I'd report it to the office or the on call senior staff member." We saw that suspected abuse was reported to the local authority and investigated when needed. However, the manager told us that concerns reported over the weekend would wait until Monday before being reported to the local authority. This process was not in line with local safeguarding adult's procedures which states that any suspected abuse should be reported immediately to the local authority. This meant that people could be at risk of not being immediately protected from harm or abuse.

People's risks were assessed and planned for to protect their safety and wellbeing. People's risks had been identified when they started to use the service and specific risk management plans had been put into place to help staff understand how to support people to manage their risks. For example, one person needed specialist equipment and the support of two staff members to help them to move. We saw that there was a risk assessment and plan in place for staff to follow and staff told us they were aware of and followed this to ensure the person's safety.

Requires Improvement

Is the service effective?

Our findings

The service did not always act in accordance with the Mental Capacity Act 2005 (MCA). The 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We found that the statutory principles of the MCA were not being applied consistently and effectively. We saw that consent forms had been signed by people's relatives on their behalf. There was no documentation that showed the individuals were unable to make their own decisions as no assessment of their mental capacity to make their own specific decisions had been carried out. Additionally, there was no evidence that these relatives had the correct legal decision making power under the MCA and therefore would be unable to provide consent to particular decisions on a person's behalf. We discussed this with the manager who told us they were now aware of this issue and were providing additional training for staff and reviewing people's care plans to correct the issues.

We saw a statement in a person's care records that said they were unable to understand the medicines they were prescribed and another statement that said they were able to consent to staff supporting them to take their medicines. These statements were contradictory and demonstrated a lack of understanding of the MCA and how it should be applied to ensure that people's legal and human rights were respected.

The above evidence shows staff had not always sought the consent of the relevant person or acted in accordance with the MCA. These issues constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most of the people and relatives we spoke with told us that staff had the knowledge and skills to support people effectively. One person said, "Yes they are good at what they do, I can't find fault with any of them." Staff told us they had received an induction before they provided support to people on their own. One member of staff told us, "My induction was good, it was an introduction to the company, a week of face to face training then shadowing experienced staff before I went out alone." Staff told us and records showed that staff received ongoing training to enable them to support people safely and effectively. Staff confirmed they received effective supervision and feedback on their performance following regular spot checks. One staff member said, "We have supervision and appraisals, it's useful. I was looking for something more and I have been supported to become a senior carer."

People and relatives told us that staff supported people to eat and drink sufficient amounts and gave people choices about their food and drinks. One person said, "They always ask what I want, such as if I want toast in the morning with a cup of tea." Another person said, "They give me my dinner but I make my own choice. They always ask and they offer me toast before I go to bed too." Staff told us they offer people choices when they support them with eating and drinking. We saw that people had plans in place to help ensure their nutritional needs were met and these were specific to each individual who required support with eating or drinking. For example, records showed that one person needed staff to cut up their meat into

small pieces so they could eat it safely and comfortably.

People were supported to maintain good health and were supported to access healthcare professionals when they needed them. One person said, "They send for the doctor if they are worried about you." A relative said, "If anything is wrong, they ring the doctor. It has happened a couple of times and they fetched a doctor. It's been sorted." We saw in one person's records that staff were concerned about a change in their mobility. Staff contacted an occupational therapist to discuss their concerns and arranged for them to reassess the person to ensure they were safe and well supported when mobilising. We saw that staff worked alongside professionals including district nurses and occupational therapists to ensure that people's health was monitored and maintained.

Requires Improvement

Is the service caring?

Our findings

People did not always receive a caring service because some people felt anxious about not knowing what time staff were going to arrive, not knowing which staff were going to arrive and being unsure about whether staff would stay for the full allocated time with them. One person said, "It's a bit like pot luck, you never know what you will get with some of them."

Some people told us they were treated with kindness and compassion and that staff were friendly towards them. One person said, "They make me feel merry. They chat about the weather, normal things, they ask how I am." Another person told us, "They are very good and respectful. I have a laugh with them." A relative told us, "They have a good laugh with my relative. It cheers her up." However, some people told us they did not have a consistent staff group and could not build relationships with staff, as they were uncertain who would arrive to support them.

Staff told us they knew people well and knew their preferences as they had got to know them when providing support to them. One staff member said, "I am a regular carer for the people I support. We have good relationships, it's better for their care to have that consistency. I love seeing people's faces light up when I go to see them." Another staff member said, "I go in to the same people and have a good relationship with them. We know them well so can recognise any changes."

People and their relatives told us they were encouraged to be involved in making some choices and decisions about their care. One person said, "I can decide what I want and what help I need and they always ask if there's anything else I need help with." A family member said, "My relative can't do much for himself now but carers always respect his choices." Staff we spoke with explained how they encouraged people to be involved in making their own decisions about their care. One staff member explained how they would talk in simple language and narrow down the options to encourage one person they support to make their own decisions, as they would struggle with open ended questions. However, records showed that people were not always involved in developing their care plans and were not always asked about their care choices and preferences.

People told us that staff listened to them and gave them the time they needed to explain their views. One person said, "My carer goes out of her way to listen if something's bothering me. It's never been too serious, but she helps me to sort it, always." A relative told us, "If my relative is worried about something they do listen and try to help her. Once, when her feet hurt they asked her all sorts of questions and reassured her and then they informed us and arranged a doctor's appointment for her."

People told us their privacy and dignity was respected. People said that they felt comfortable when staff supported them with personal care and that they always protected their dignity. A relative said, "They always knock on the door and they always say hello to him using his preferred name. They never feel intrusive to him." One person said, "The carers are always themselves and treat me like who I am. It's good because it's not like I'm a patient, we have a good laugh. They always do the job they're paid to do, they see I'm alright but also I get on well with them and vice versa." Staff told us how they treated people with dignity

and respect. One staff member said, "I treat people how I would like to be treated."

People told us that staff encouraged them to be independent and they appreciated this. One person said, "They don't take over if I am trying to do something unless I ask." Another person said, "I do what I can. I wash my own hands and face, that sort of thing. They let me get on with what I can."

Requires Improvement

Is the service responsive?

Our findings

People and relatives knew how to raise a concern or complaint, however, a number of people told us they had raised concerns or complaints and had not received a satisfactory response. One person said, "Several times I've rung them and complained. They don't tell us any results of any investigation they made." Another person said, "I contacted Custom Care and had a word with them but it's made no difference." A relative told us, "We made a complaint. It was because they didn't turn up one night about a month ago. So far we've heard nothing and it's not changed." This meant that people's concerns and complaints were not being acted upon and people's feedback was not being used to make improvements to the service.

Some people told us they had difficulty in contacting the service in order to make a complaint or were not confident that their issues would be addressed. One person said, "Sometimes if I'm kept waiting I try to phone them. You can never get through. It's engaged or they haven't got time to talk to you." A relative said, "I don't trust Custom Care to deal with the issues. That's why I contacted Social Services instead." This showed that the service was not responsive to people's feedback and complaints.

There was a complaints policy and procedure in place, however; we found that this was not always being followed. We looked at the log of complaints and we found that not all concerns or complaints had been logged in line with the procedure. People told us they had complained and we could not see that their issues had been recorded. Some complaints had been recorded but people had not received acknowledgements or outcomes of their complaints in line with the providers own procedure.

The above evidence shows there was no effective system in place for receiving, recording, investigating and responding to complaints. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were involved in creating their support plans and we saw that the plans were detailed enough for staff to know how to support people. We saw that plans reflected how people liked to receive their support and included personalised information including likes, dislikes and a brief life history. We saw that one person had a very specific plan for how they liked to be supported when eating their meals. This included which specific cutlery to use, where they liked to sit and what food they liked to eat. Staff were familiar with the content of people's plans and knew their likes, dislikes and preferences. One staff member said, "All the information we need is in the care plan. We read them and all the information is in there. I go to the same people every week though so I know them well."

However, people told us they were not asked for their preferences in relation to the gender of staff who supported them. Some people did not have a preference of gender of staff so were unaffected by this, however some people told us they would prefer to have been offered a choice. One person said, "On two occasions I've had a man but I prefer women. I haven't been given a choice. They send whoever is available at the time." Another person said, "When I first started, I did have a man but I wasn't given a choice. He's gone now so it's all women carers. We should be asked really." This meant that people did not always receive personalised care that was responsive to their needs.

Inadequate

Is the service well-led?

Our findings

Effective systems were not in place to enable the manager or provider to consistently assess, monitor and mitigate risks. We looked at records of safeguarding adults referrals. The records were not organised. We could not easily tell what had been reported, to whom and when. We found safeguarding incidents had been reported when required however the records did not clearly show what the outcome of the safeguarding referral was and whether a protection plan was required to mitigate any ongoing risks. The branch manager, with overall responsibility for safeguarding matters was not aware that safeguarding alerts should be made to the local authority without delay and told us that any issues reported to 'on-call' over the weekend, would wait until Monday before being reported to the local authority. This meant that people's safety could be compromised over the weekend period and that people could continue to be at risk of harm because the correct referrals were not being made and the correct procedures were not being followed. Additionally, the system in place was not effective to ensure suitable oversight into safeguarding adults' activity to allow risks to be monitored.

We found that effective systems were not in place to enable the manager or provider to consistently assess, monitor and improve the quality of the service provided. Quality monitoring systems were in place but they were not always effective and left potential for issues to be missed. For example, team leaders were responsible for completing audits of daily medication administration records. However, we saw gaps in topical creams administration that had been missed by team leaders and later identified by other managers. We saw that the provider was working on introducing a new system to mitigate the risks of these errors occurring again but this was not yet in place.

There was no evidence of analysis of trends or overview of risks to allow for safety to be monitored and improved upon. We saw that some people had experienced falls and these were recorded in their daily care records but were not always recorded as incidents to allow the manager to have an overview of risks and to ensure that necessary actions were taken to prevent future incidents. The managing director told us that different systems were in place that did not communicate with each other and that this was being reviewed at provider level. We also saw that systems and processes were complicated and information was recorded in numerous different places which made it difficult for the manager to have an overview of issues requiring action.

We found that effective systems were not in place to ensure that people's feedback was acted upon for the purposes of evaluating and improving the services provided. We saw that quality assurance telephone calls were made to people but action was not always taken to act on their feedback. One person said, "They could do more. It's easy to ask questions but what about answering them?" Another person said, "We've had questionnaires in the past but some of the questions aren't relevant. I'm not convinced they act on them anyway." We saw that some people's feedback was that they were unhappy about missed care calls but there continued to be occasions where people's care calls were missed. This showed effective action had not been taken to address people's concerns and effective systems were not in place to ensure that people received the care they required. There was also no evidence of any overview or analysis of feedback received.

There was a lack of clear leadership within the service which meant that people remained unhappy with the service they received. We saw that there continued to be late and missed care calls despite the provider having action plans in place to make improvements. We saw that action plans had been in place for some time and though some improvements had been made, there were still many significant areas of service delivery which required further improvement. For example, the service was not following the principles of the MCA, was not responding to complaints sufficiently and was not consistently ensuring that people received care they were satisfied with.

The above issues constitute a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no registered manager in place, which is a condition of registration with us. There was a branch manager in place but they were not registered with us. We saw that work was taking place to make improvements to some areas of service delivery and a number of different managers were involved with supporting the service. For example, we saw that all staff were being issued with mobile phones to enable them to log in and out when they complete each person's visit. The provider hoped this would help improve punctuality, communication and accountability. Although the provider was aware of many of the issues identified during the inspection and we saw they had an improvements action plan in place, there were still significant improvements required. There was no registered manager, specifically responsible to take the leadership role in addressing issues identified and driving continuous improvements. This made it difficult for the provider to be confident that changes would be successfully implemented and sustained.

People and their relatives had mixed views about whether the managers of the service were approachable and whether the service demonstrated good management. Some relatives did not know who the manager was. Some people told us the manager had telephoned them to check they were happy with the service. One person said, "I spoke to her on the phone once and she was helpful." Another person felt they had noticed improvements recently and said, "It seems to be coming together a bit more now."

Staff felt supported by the managers. However, they felt that improvements were required with the organisation of the service delivery. One staff member said, "We need better organisation of rotas and a few more staff. Calls are not always planned in a good order so you end up being early or late for people." However, staff had positive views about the planned changes taking place within the service to make improvements. One staff member said, "The new systems coming in to place should help." Another staff member said, "The changes are going to be for the better. I think we will be able to deliver a better service."

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints There was not an effective system in place for receiving, recording, investigating and responding to complaints.

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 11 HSCA RA Regulations 2014 Need for consent The service had not always sought the consent of the relevant person or acted in accordance with the Mental Capacity Act 2005.

The enforcement action we took:

Issued warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were not in place to enable the manager or provider to consistently assess, monitor and mitigate risks or to consistently assess, monitor and improve the quality of the service provided. There was no evidence of analysis of trends or overview of risks to allow for safety to be monitored and improved upon. Effective systems were not in place to ensure that people's feedback was acted upon for the purposes of evaluating and improving the service.

The enforcement action we took:

Issued warning notice