Care Homes Stoke Limited

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Inspection report

Park View Day Centre
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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?	**Inadequate**

Summary of findings

Overall summary

We completed an announced inspection at Care Homes Stoke Limited on 9 and 10 November 2016.

We identified multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration Requirements) Regulations 2009.

The service is registered to provide personal to people in their own homes. At the time of our inspection 171 people were using the service. 58 members of staff were reported to be working at the service.

The service had a registered manager. 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 and associated Regulations about how the service is run. In this case, the registered manager was also the provider.

At this inspection, we found that the provider did not have effective systems in place to assess, monitor and improve the quality of care. Care calls were not being monitored and staff competence was not being checked. There were no audits in place to check the information contained in people's care plans and risk assessments. This put people at risk of receiving unsafe care.

Risks to people's health, safety and wellbeing were not identified, managed and reviewed and medicines were not managed safely.

There were insufficient staff delivering care at the service and there had been an increase in late and missed calls. This had impacted on people's health and wellbeing.

People's care needs were not regularly reviewed. People's care plans were not accurate and up to date which meant staff didn't always have the information they needed to provide safe and consistent care.

The provider did not understand the requirements of the Mental Capacity Act 2005 and staff were not trained in this area of care delivery. Staff did not always understand what was meant by mental capacity.

Staff received training in order to meet people's individual care needs and keep people safe. People's health was monitored and managed to promote their health and wellbeing.

People were treated with dignity and staff were able to describe how they delivered care to meet people individual needs.

Effective systems were not in place to ensure concerns about the quality of care were investigated and managed to improve people's care experiences.

The provider did not notify us of reportable incidents and events as required.

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 safe.

Care plans and risk assessments contained insufficient information to keep people safe and they were not regularly reviewed and updated.

There were insufficient staff numbers to ensure people received the care they needed at the time that had been agreed.

Medicines were not being managed safely.

Staff knew how to recognise types of abuse and how to report them. Staff had received training in relation to safeguarding vulnerable people.

Is the service effective?

Requires Improvement

The service was not always effective.

The requirements of the Mental Capacity Act 2005 were not always followed. Staff and the provider did not understand the requirements and there was no evidence that people's mental capacity had been considered in their care delivery.

Staff received training in most areas of care, however, regular supervisions and spot checks were not carried out to monitor and support staff in their skills and knowledge.

People's health needs were monitored and referrals made to health professionals to ensure their health, safety and well-being.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were treated with kindness and dignity but care plans did not always reflect people's personal histories and there was little evidence of people's involvement in their plans of care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was little evidence that people and their representatives were involved in the planning of their care. Care plans and risk assessments were not person centred or up-to-date.

Complaints were not always responded to appropriately and people's views not always considered and used to improve the service.

Is the service well-led?

Inadequate

This service was not well-led.

Calls were not being monitored to ensure people received the care they needed and there were no effective systems in place to monitor the quality of care people received.

Although staff reported to be well supported, staff competence was not being assessed to ensure people were receiving safe care.

The service was not notifying CQC as required incidents of alleged abuse.

Care Homes Stoke Limited

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 9 and 10 November 2016. The inspection was announced and was undertaken by one inspector. We gave the provider 48 hours' notice of the inspection as we needed to be sure that the relevant people would be available. In the two days prior to the inspection visit we spoke with people who used the service. Two experts by experience carried out telephone calls to people during the week of the inspection to gain people's views and experiences of their care delivery. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our experts had experience of learning disability services as well as care delivered to the elderly at home.

We reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law. We also reviewed information sent to us by the provider through the submission of a Provider Information Return and we spoke with the local authority to find out their views of the care provider as commissioner of the care.

During our inspection we talked to 14 people who used the service and nine relatives of people who used the service. We spoke with 12 members of staff including six care workers, the registered manager, the care manager, the HR manager, the care co-ordinator and two senior care workers. We looked at nine care records for people using the service as well as records related to the delivery of people's care. We reviewed staff files to ensure staff were recruited safely and reviewed how the quality of the service was being monitored. We also looked at call schedules, incidents, accidents and complaints.

Requires Improvement

Is the service safe?

Our findings

People we spoke with described staff delivering the care they needed safely. However, when we reviewed care plans and risk assessments for nine people using the service we found that there was insufficient detail within the care plans and risk assessments to keep people safe. For example, several people using the service had diabetes. Their nutritional risk and needs in relation to this was not adequately assessed or planned for. There was also insufficient detail or guidance for staff in relation to people's medication needs. Several of the care plans and risk assessments we looked at had not been reviewed and one had not been updated since 2013. We saw that the service employed a high number of staff and there was a high turnover in staff. The lack of detail for staff on how to care for people posed the risk that people may not receive safe and appropriate care. When we spoke with staff about people's care needs they told us that they relied on being told verbally what people's needs were and few staff referred to information in people's care plans. Staff were not given enough up to date information about the people they were caring for to ensure their safety.

We looked at the arrangements in place for the management of people's medicines during our inspection to ensure that this was being done safely. We found that staff were not given adequate information about the medicines they were administering to people in the care plans we looked at and that this had not always been risk assessed fully to mitigate any possible risks posed to people by this process. A number of people whose care we looked at during our inspection were having their medicines administered to them. Staff were completing Medicines Administration Records (MARs), however, these were not being reviewed by the provider to pick up any errors or missed medications.

Care records showed that people did not always receive the medicines they needed at the prescribed times because some care calls were late or missed. For example, one person had been found collapsed on the floor following a missed call. This person had diabetes and had not received the medicines they needed to manage this condition. This meant the person wasn't supported to receive their medicines as prescribed and they experienced harm as a result. We also found that another person had been given too much of their prescribed medicine and that some medication had been found at people's homes which had not been administered.

We spoke with the provider about how they were assuring themselves that people were getting their medication safely. The provider explained that an action plan was in place which included the introduction of medication audits and competency checks for staff. At the time of our inspection there was no robust system in place to check whether staff were competent to administer people's medicines and we saw that checks on staff administering medicines were not done regularly. Records showed that only two staff members had been checked during November 2016 and that prior to this one staff member had been checked in August 2016. When we discussed this with the provider they told us that these checks had not done as planned and that they were looking to address this shortfall. We could not be assured that people were getting the medicines they needed and found instances where medication errors had occurred which had not been picked up or addressed by the service at the time they happened.

Some people we spoke with told us about incidents when they had missed their medication due to calls being attended late. Some of the staff we spoke with raised concerns about the quality of training delivered in relation to administering medicines and felt that more checks on this should be done when they were delivering care to people in their homes. One staff member said: "I came across my first stoma bag the other day and had to call for help." This staff member told us that they were not equipped to carry out some tasks in relation to administering medication following the training delivered by the service.

We found that incidents which took place at the service had been documented and action taken as a result. For example, we saw that one incident involving a person missing a call which had resulted in them being found on the floor having not had their medication or their breakfast had been reported to the local authority as a safeguarding concern. This missed call had been identified by another care agency prior to the provider being aware that the person had missed the call. Another incident involved an alleged theft from a person using the service. Action had been taken in relation to these incidents and they had been appropriately reported in order to safeguard people. However, we found no analysis of incidents over time to look for patterns, or of lessons learnt as a result of looking at incidents. We discussed this with the provider who told us that this wasn't currently happening at the service but that it was an area they were looking at in order to improve. This meant that there was a risk of harm to people using the service as action was not being taken to manage potential risks to people effectively.

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

Some of the people we spoke with described their calls being affected by staffing numbers. One person, when we asked them about whether the staff arrived on time, told us: "It depends. Certain ones are on time others are not. Depends who it is. I had a missed call completely yesterday in the morning and had to call my sister to come as I have to have my tablets on time with my food or I get a seizure. I phoned the on-call and they said they knew nothing about it. I have been three years with this company and it seems to be getting worse." Another person said, "They keep changing all the time lately. Yes they are sometimes late. If very late I phone the office to ask where they are. They look into it. Sometimes they call me back, but not always." We found that people were not always getting the calls they needed and that staffing levels and the way in which calls were being scheduled due to staff numbers were the reason for this.

The service had what they described as a "rolling recruitment programme" in place. They were advertising for care staff and described having a high turnover in staff. A radio advertisement for care workers was due to go out at the time of our inspection. We found that calls were, at times, being scheduled with little or no travel time between them. We found instances where calls overlapped with the previous call ending after the next call was due to start. Staff reported that, at times, this caused problems for them arriving to calls at the scheduled time. We discussed this with the provider who told us that this should not be happening. However, there was no monitoring of call schedules or of the calls themselves and so the provider was unable to tell us whether staff were able to meet their calls across the service. There was no system in place to ensure people were being kept safe by receiving the care calls they needed.

Staff we spoke with described being rushed at times and stated that weekends were particularly difficult. One staff member said: "There's a lot of missed calls. The biggest problem is lack of communication." Another staff member told us: "The biggest fault with the company is staff turnover." We discussed missed calls with the provider who told us that these had increased recently and that the retention of staff was an area they were looking at. During our inspection we found that there were not sufficient numbers of staff to care for people safely.

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

People were supported by staff who knew how to recognise when people were at risk of abuse and knew what action they should take to keep people safe under these circumstances. Staff had received training in relation to safeguarding people who used the service and this training was refreshed when needed. We saw that where incidents had taken place of possible or alleged abuse, action had been taken to safeguard people by referrals being made to the local authority. Staff and the management had an understanding of how to protect people from abuse.

We found that staff had been recruited safely and that the required checks had been carried out to ensure they were safe to work with vulnerable people.

People we spoke with told us they felt safe with the staff who cared for them. One person said: "Yes I feel safe. They are very good and careful with me." Another person's relative told us: "They are all very good. The way they take their time in handling him is admirable." Nobody we spoke with raised any concerns about their safety in terms of how staff cared for them.

Requires Improvement

Is the service effective?

Our findings

We found that staff and the provider lacked knowledge about the Mental Capacity Act 2005 (MCA), despite a number of people who used the service having conditions which may have meant that they lacked the mental capacity to make certain decisions about their care. 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. There were no mental capacity assessments in the documentation we looked at and no evidence that where people may have lacked capacity an assessment had been considered to determine this in relation to the delivery of their care.

We discussed the requirements of the MCA with the provider who was unaware of their obligations in relation to ensuring that people's mental capacity had been assessed when needed in order to ensure decisions were made and documented in their best interests. The provider told us that MCA training had been booked for themselves and all staff working at the service to improve knowledge and understanding in this area. Staff lacked knowledge about the MCA and were unable to explain to us what the requirements meant for the people they looked after. One staff member referred to a person having: "A thing with their memory" and said they were: "Not really with it." This demonstrated a lack of understanding in relation to mental capacity.

During our inspection we asked people whether they consented to their care delivery and whether staff consulted with them before they provided care. Most of the people we spoke with confirmed that their consent was sought prior to their care delivery. One person said: "Yes they do my plan and I agree it with them."

We found that staff were trained in most areas of care delivery and that training was updated when required. Staff had not had training in the MCA but this had been booked. Supervisions were not regularly carried out and there were several members of staff who had not received a supervision over the last 12 months, according to the records we were shown. Spot checks to assess the staffs' competencies were also not carried out routinely and appeared to happen on an ad hoc basis. This meant that staffs' development needs were not being regularly assessed to identify knowledge and skills gaps.

Staff were not being adequately supported to ensure they delivered safe and effective care to people. However, when we spoke to staff they reported feeling supported by the management and said that they could approach management for help and support whenever they needed it. One staff member said: "It's good. The management are very supportive. They come across more as friends than managers but you still respect them." Another staff member told us: "You've got a good support network. They tend to work with the carers rather than bark at them." All of the staff we spoke with felt that they could approach management and that they would be supported, however, formal supervisions and spot checks to assess staff competency were not being carried out.

Some of the people using the service had diabetes and we found that there was insufficient detail for staff in these people's care plans and risk assessments. Staff were not given enough information to provide people with the support they needed with their nutrition. One person was on a pureed diet and was non-verbal. Their care plan and risk assessment in relation to their nutritional needs did not guide staff on how this person required their food and the documentation was dated October 2015. Staff referring to care documentation would not have enough information to know the person's needs if the person was unable to tell them.

Staff were making referrals to health professionals when it was needed. We saw evidence in care records that this was being done and that health professionals such as GP's were contacted when staff were concerned about people's well-being. People's health needs were monitored and the service responded when they identified that people may be unwell and need the input of a health professional. This was documented in people's care records and in the daily notes made by staff.

Requires Improvement

Is the service caring?

Our findings

Some of the people we spoke with described the carers being rushed in their work and said that this impacted on how much time they spent with them. One person commented that: "Sometimes they are rushed. It's not the girls' fault it's the people doing the rota in the office. They don't know what they are doing."

We found from looking at the call schedules that staff were, at times, spending less than their allocated time with people and we saw that calls were scheduled in a way that meant in order for calls to be attended on time, staff had to cut calls short. We spoke to staff about their call schedules. Many staff told us that they managed the lack of travel time between calls by starting their shifts early or catching up on themselves during their breaks. This meant that people were not always getting the care they needed at the times they wanted or had agreed it. The service was not providing care to meet people's needs as the call schedules were not enabling staff to stay on calls for the agreed time. This demonstrated a lack of care for the people using the service.

Staff we spoke with all described knowing the needs of the people they cared for and talked about delivering care to people with respect. One staff member said: "I get on with all the people I go to. I've got a bond with them." Staff talked about giving people privacy and respecting their wishes when they visited them at home to deliver their care. Staff did tell us that at times they were rushed and that this impacted on the amount of time they could spend engaging with people. This was also mentioned by people who used the service, some of whom said they felt the carers had less time recently.

People who used the service spoke positively about the staff who cared for them at home. One person said: "The girls are wonderful. So careful with me and always talking as we go along while they are seeing to me." Another person told us: "They are all very good even the ones that cover. They know what I need and are very respectful of that." Someone else commented that: "Yes they are excellent. No complaints. They are thoughtful and careful with me and I trust them completely." Where people who used the service were not able to speak with us, we talked to their relatives, who were equally positive about the caring nature of the staff looking after their relation. One relative told us: "They are good, no problems with that. The new ones are nervous at first because my wife has mental and physical problems but they are very caring in how they handle her." Another relative said: "Yes they are very good with him. He has a stair lift and they put him in the safety chair and buckle him in but are always very careful and considerate."

Requires Improvement

Is the service responsive?

Our findings

Staff had been trained in relation to person-centred care, however, the care records we looked at for people lacked personal details and did not reflect a person centred approach to their care delivery. Standard statements appeared to be used and some of the care records were very factual in their descriptions. There was little evidence of people's involvement in their plans of care and little evidence that people's own views had been considered. For example, a question in one care plan was: "What matters to [person using the service]?" The documented response was "What matters to [person] is her toilet regime is managed." The care plan did not give any information about this person's personal history, likes, dislikes or preferences in terms of how they wanted their care delivered to them.

We found little evidence in the care records we looked at that people were involved in the planning of their care. Care plans were not person-centred and often lacked any detail about how people would have liked to have their care delivered to them. However, when we spoke with people and their relatives they told us that staff worked to meet people's individual needs and that staff understood their personal preferences. One person told us: "Yes they know all my likes and things."

Staff we spoke with were able to explain people's like and dislikes and they told us how people liked their care to be delivered. Staff did, however, refer to times when they were late for people's calls and described being rushed and lacking the time to always deliver the care people needed. One staff member described the effect of being rushed and under pressure to meet the calls on their schedule: "It has a massive impact on your service users and on your committed carers." The service was not always responsive to people's care needs due to carers being late or missing people's calls. Care was not always personalised as staff were rushed in their care delivery. People told us that staff were unable to spend time with them and that calls had become late and more rushed in recent months. One person said: "The regular ones are on time but others filling in come late sometimes as late as one hour."

We found that one person who had recently been discharged from hospital had not had their care needs reviewed and reported to us that they needed two carers to move them. The service had not reviewed this person's needs on their discharge from hospital and their care records did not reflect their current needs. The service was not responsive to people's changing needs.

We looked at the complaints recorded by the service and found that seven complaints had been logged in 2016. We found that complaints were not always responded to satisfactorily and that, although they were recorded, the response was not always adequate. For example, one person's relative had made a written complaint regarding the length of time a carer had spent at their relative's care call. The relative stated in the complaint that the carer had attended the call for six minutes, rather than the agreed hour. The service had not responded to this complaint in writing and no apology was recorded. When we spoke to the provider about this they explained that a telephone call had been made to the complainant and acknowledged that this had not been a satisfactory response to this complaint. There was little evidence available about the investigation in relation to this complaint and no evidence of any lessons learnt.

Although surveys had been issued to people who used the service to obtain their views in early June 2016 these had not been looked at or analysed and there was no evidence that the feedback had been used to make improvements to the service. People's views were not always being considered in relation to the delivery of their care.

Inadequate

Is the service well-led?

Our findings

Some of the people we spoke with reported that the office was "disorganised" and that communication was an issue. People had provided feedback to the service in June 2016 that they: "Have problems with staffing levels" and that the company, "Seems to lose a lot of very good carers". This feedback had not been collated and used to improve the service and we found that staffing levels and staff retention were on-going issues.

There was no effective system in place at the time of our inspection to monitor care calls being delivered by the service. The provider, who was also the registered manager, explained that any missed or late calls identified were done so through staff or people who used the service and their relatives letting the office know. The service reported missed and late calls to the local authority by sending them emails to inform them of how many missed and late calls they knew had occurred. If a call was late or missed and staff or people using the service did not alert the office, the provider would be unaware that this had happened. The provider explained to us that they were in the process of implementing a new system which would allow all calls to be monitored and that the contract for this system had been agreed to. However, at the time of our inspection there was no robust system in place to monitor if people were receiving their care as agreed or not. This placed people at risk of harm as some people may not have been able to let the office know if their call had been missed or late. Many of the people using the service relied on their calls to receive their medication. People and staff had reported to us that late and missed calls were of increasing concern.

Care records contained no evidence to show the information contained in them was regularly reviewed and updated. In some cases the last date on the plans and risk assessments was in 2013. This meant that staff were not being given up-to-date information about people's care needs. The provider informed us that these care records would have been checked but they were unable to evidence this. There was no record of people's current care needs and so we were not sure how the provider was assuring themselves that people's needs were being met.

There were no checks carried out in relation to the administration of people's medicines. The provider was unable to tell us how they were assuring themselves that people got their medicines as required. This posed a risk to people using the service as there were no adequate checks in place to ensure people's care was being delivered safely. As many people using the service required their medicines to be administered by the service, the provider lacked the management oversight to assure them that this was being done safely.

We asked the provider to show us the programme of checks that were carried out to enable them to measure the quality of the service being delivered. We were told that no checks were taking place but audits were due to be implemented over the coming months.

Supervisions for staff and spot checks on them in the community were not completed regularly. Records showed that only four spot checks and seven supervisions had been carried out on over 50 staff members since July 2016. This meant staff competence was not being effectively monitored to ensure that care was being delivered safely and in line with people's agreed care needs. When we discussed this with the provider they told us that there had not been the capacity to carry out these supervisions and checks as needed but

that it was an area they were working on. The provider did not have a clear picture of staff performance and possible training needs.

There was no system in place to monitor and assess staffing levels and due to the absence of a call monitoring system there wasn't the data to allow for this analysis. Staff reported being rushed and struggling to meet calls, however, no action had been taken to address this.

The service had recently employed the services of an external consultant to look at how the service was being run and we found that several areas of concern had been identified through this process. However, at the time of our inspection the service was not being adequately managed and there were no effective systems in place to monitor the quality of care being delivered.

Staff reported to be well supported by the management team and all told us that they felt the management team were approachable and that they would support them in any issues they may have. One staff member told us: "I've never known a company to drop what they're doing to speak to you." Another staff member said: "We work really well as a team. They go out of their way to make sure everybody's happy." Staff were generally happy working at the service and did feel well supported. Staff did describe being under pressure and some of the call schedules we reviewed indicated that staff were asked to undertake calls with no travel time in between and overlapping calls which would have been difficult to attend on time. When we showed some examples to the provider they told us that they had not "checked the runs for some time." This indicated a lack of management oversight in relation to call schedules and care delivery.

A survey had been issued to people using the service in June 2016. We were shown the results of these. There were issues raised by people through the survey, however, the provider informed us that they had not yet had time to analyse or consider the feedback due to lack of time. Issues people raised had therefore not been addressed or considered by the service.

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

During the inspection, we were made aware of two incidents of alleged abuse. These incidents had not been reported to us as required under our registration regulations. This meant we did not have access to the information that enables us to effectively monitor the safety of the service. When we discussed this with the provider, they informed us that they had not been aware of this requirement.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

During this inspection we found that improvements were needed to monitor the quality of care delivery and to enable staff to deliver the care more effectively.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider was not notifying CQC of incidents of alleged abuse as required.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was failing to assess the risks to the health and safety of people using the service. There were not proper and safe systems in place to manage medicines.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were not systems in place to enable the registered person to assess, monitor and improve the quality and safety of the services provided. There were not systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of people using the service. Records were not accurate or up-to-date.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of staff to ensure people received safe care.