Westminster Homecare Limited

Westminster Homecare Limited (Enfield/Waltham Forest)

Inspection report

Refuge House
9-10 River Front
Enfield
Middlesex
EN1 3SZ

Tel: 02082166300

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 24 and 25 September 2018 and was announced.

At an inspection of this service on 4, 5 and 6 April 2017 we found that some aspects of the management of medicines were not safe and so there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found that the quality assurance systems regarding medicines auditing and the management of staff rotas and late visits were not well managed and so there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Due to the serious nature of the breaches we took enforcement action against the registered provider. Two warning notices were issued, for breaches of Regulations 12 and 17. Warning notices give the provider a specific time frame in which to improve in the areas identified at the inspection.

On 1 and 7 September 2017 we undertook a focused inspection to check whether the service had met the breach of legal requirements in relation to Regulations 12 and 17, concerning safe management of medicines, quality assurance of medicines and staff rotas, which had resulted in enforcement action. We found that the service had failed to meet the requirements of the enforcement action we had taken and continued to be in breach of Regulations 12 and 17.

Following that inspection, we wrote to the provider using our powers under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, to ask the provider to send specific information on actions they intend to take to address the concerns that we had raised and by when to improve the key questions of 'Safe' and 'Well-led' to at least good. An action plan was submitted which detailed the steps they planned to take to make the required improvements.

The local authority for Enfield had placed an embargo on Westminster Homecare (Enfield / Waltham Forrest) following the inspection in April 2017 to prevent the service taking on any new people. The provider also implemented a voluntary restriction on referrals from the London Borough of Waltham Forest until the necessary improvements had been implemented. The provider lifted the voluntary suspension for new referrals from Waltham Forest in January 2018. The London borough of Enfield lifted the embargo place on the service in August 2018 after significant improvements had been noted.

Westminster Homecare (Enfield / Waltham Forest) is a domiciliary care agency. It provides They provide a wide range of personal care options to people living in their own houses and flats in the community. It provides a service to older people, some of who are living with dementia. At the time of this inspection the service was supporting approximately 173 people.

Not everyone using Westminster Homecare (Enfield / Waltham Forest) receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

A registered manager was in post at the time of this inspection. 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.

During this inspection we found that the provider had made significant improvements and had addressed the breaches previously identified and was now meeting the regulatory standards.

However, we continued to receive feedback from people and their relatives that timekeeping remained an on-going concern and that people and their relatives did not believe that the service communicated with them effectively especially when care staff were running late or when changes had been made to the care staff they were scheduled to receive. We have made a recommendation around further improving systems and processes when allocating sufficient travel time so that people receive their care call on time.

People received their medicines safely and as prescribed. The provider had implemented robust systems and processes to ensure that medicines management and administration was safe and closely monitored. However, some concerns were noted around the recognition of certain high-risk medicines and their side effects and the documentation around as and when required medication.

The registered manager and provider had introduced a variety of processes which enabled the service to regularly and comprehensively monitor the quality of care provision. Issues and concerns identified were clearly recorded and where improvement and learning were required this had been implemented.

Risks associated with people's health and care needs were identified through the care planning process. Guidance and information was available for care staff to follow so that people's known risks could be reduced or mitigated to keep people safe.

Care staff were able to describe the different types of abuse people could experience and clearly explained the steps they would take if abuse was suspected.

Safe recruitment processes were followed to ensure only those care staff assessed as safe to work with vulnerable adults were employed.

Care staff received appropriate training and support to effectively carry out their role. This included induction, refresher training, supervision and an annual appraisal.

People were supported with their nutrition and hydration needs where this was an identified and assessed need as part of the person's package of care.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice.

The service supported people with their health care and medical needs where required. Where people required additional care and support, appropriate referrals had been made to the relevant healthcare professionals.

Care plans were person centred and detailed and clearly set out the person's support needs which enabled care staff to deliver care.

People and their relatives told us that care staff were caring and engaged with them whilst supporting them with their needs.

People and their relatives knew who to speak with if they had any complaints or issues to raise. However, most people and relatives told us that they did not feel their complaints were always adequately addressed.

Most people and their relatives knew their allocated care coordinator more than they knew who the registered manager was. The care co-ordinator was the person who was always in contact with them about their care and support package.

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 always safe. Overall people received their medicines safely. However, records were not always complete and certain high-risk medicines were not always recognised and risk assessed.

People told us they felt safe with the care staff that supported them. Care staff were able to explain the actions they would take to protect people from abuse.

People's identified risks associated with their health and social care needs had been clearly assessed with guidance to staff on how to reduce or mitigate any known risks.

Recruitment processes were robust and ensured that only care staff assessed as safe to work with vulnerable adults were employed.

Accidents and incidents were recorded with details of actions taken, learning and improvements that could be made to prevent future re-occurrences.

Is the service effective?

Good

The service was effective. People's needs were assessed prior to any package of care being introduced.

Care staff received appropriate training and support to effectively carry out their role.

People were supported with their nutrition and hydration where this was an identified and assessed need.

The service supported people to access health care services where this was a required need.

People, where able, had consented to the care and support they received and this was documented. Care staff had an awareness of the Mental Capacity Act 2005 and how this impacted on how they supported people.

Is the service caring?

Good

The service was caring. People and their relatives told us that care staff were kind and compassionate and supported them in a caring manner.

People and their relatives had been involved in the planning and delivery of their care.

People and their relatives confirmed that their privacy and dignity was always maintained and that they were always treated with respect.

Is the service responsive?

Good

The service was responsive. People and their relatives knew who to speak with if they had a complaint or concern to raise. However, some people and relatives did say that their complaints and issues were not always acted upon.

Care plans were person centred and details and gave clear guidance to care staff on how the person was to be supported.

People and their relatives told us that the regular care staff that supported them knew them well and provided care and support that was responsive to their needs.

Is the service well-led?

Requires Improvement

The service was not always well-led. The service and provider had implemented significant improvements to the way in which the quality of care and support delivered was monitored. Issues identified were addressed with action plans in place to support improvement and further learning.

However, most people and their relatives continued to raise concerns around the timekeeping of care staff, that they were often late for their call and that there was poor communication from the office to inform them of this or of any changes that had been made.

Staffing rotas still showed that staff were allocated only five to ten minutes travel which did not consider the mode of travel care staff used. People continued to experience late visits. Care staff told us that they managed their own rotas so that they could get to people on time.

Care staff felt that the support they received from management had improved and that they could speak to manager at the office at any time.

Westminster Homecare Limited (Enfield/Waltham Forest)

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 24 and 25 September 2018 and was announced. We gave the service 48 hours' notice of the inspection because the location provides a domiciliary care service and we needed to be sure that someone would be available to support us with the inspection process.

The comprehensive inspection was carried out to ensure that the service was meeting legal requirements and that action had been taken to comply with two warning notices that had been issued to the provider and registered manager. The service had been in continued breach of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at previous inspections, specifically regarding the safe management of medicines, medicines audits and staff rotas.

This inspection was carried out by three adult social care inspectors, a pharmacist inspector and four experts 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. The experts by experience supported this inspection by carrying out telephone calls to people who used the service and their relatives.

Before the inspection, we checked for any notifications made to us by the provider and the information we held on our database about the service and provider. Statutory notifications are pieces of information about important events which took place at the service, such as safeguarding incidents, which the provider is required to send to us by law. We also looked at action plans that the provider had sent to us following the last inspection in September 2017.

We also used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we spoke with 24 people using the service, 14 relatives, 22 care staff, one senior carer, one care co-ordinator, one office administrator, the registered manager, two care managers, the training manager, the operations manager and the operations support manager.

We reviewed the care records for 11 people receiving a service to see if they were up-to-date and reflective of the care which people received and 13 people's medicine administration records. We also looked at personnel records for ten members of staff, including details of their recruitment, training and supervision. We reviewed further records relating to the management of the service, including complaint and safeguarding records, to see how the service was run.

Requires Improvement

Is the service safe?

Our findings

We received mixed feedback from people and their relatives about whether they felt safe with the care and support that they received from care staff. When we asked people if they had confidence in the care staff that visited them one person told us, "Yes, I have, in the ones that come here." Another person when asked if they felt safe replied, "I do feel safe with them but there is just so many different ones." A third person commented, "I feel like they [the carers] just come and go as quick as they can so no, I don't feel safe, they don't care." Relatives' feedback included, "I am sure [person] is safe with them, family and friends are in every day and we are often there when the carers are and they have been very good with her", "Yes, I think so but I am always around to watch them so I know my relative is safe" and "I think she [person] is safe but only because I am always checking on the carers."

At the last focussed inspection in September 2017 we found that the service was in continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the safe management and administration of medicines. During this inspection we found that the service had made significant improvements to ensure people received their medicines safely and as prescribed.

During the inspection we checked medicines risk assessments, medicines administration records (MAR), medicines policy and systems for the management of medicines. People's preferences on how they would like to receive their medicines had been clearly recorded. Some people were prescribed creams to be applied to their body. Care staff members applied these to people and recorded this on their MARs. Care plans had details on the level of assistance people needed to take their medicines.

The provider had carried out monthly audits of MARs to identify when medicines were not given to people by staff as prescribed. We found minimal gaps in the recording of medicines given to people. This provided assurance that people were receiving their medicines safely. Where gaps were found we saw evidence that action had been taken as a result of these audits to ensure staff gave people their medicines safely.

However, we did note that certain high-risk medicines had not always been identified as high risk due to the lack of awareness around these medicines. For example, staff members had not identified medicines prescribed to people as anticoagulants which have similar side effects and are also considered high-risk medicines. Anticoagulant medicines are medicines prescribed to thin blood and prevent blood clots. This meant there was a risk that staff members may fail to identify the likely side effects of these medicines. We also noted that where people had been prescribed 'as and when required' medicines, PRN protocols were not always in place to give direction and guidance to staff on how and when this medicine should be administered. 'As and when required' medicines are medicines that are prescribed to people and given when required. This can include medicines that help people when they become anxious or are in pain. We highlighted these concerns and lack of awareness to the registered manager and provider who gave assurances that these issues would be addressed.

We saw evidence staff members received training for handling medicines. There was an annual review of their competencies relating to managing medicines. There was a system in place to report and investigate

medicine errors and incidents to help learn and prevent them happening again.
The service was no longer in breach of the regulations for safe management and administration of medicines. However, further improvements were required where minor issues had been noted around further awareness of high risk medicines and lack of PRN protocols.

Since the last inspection in September 2017 the service had received and raised a high number of safeguarding concerns with the relevant local authorities and the CQC. We spoke with the registered manager about these concerns who explained the processes involved in dealing with and investigating all concerns raised. Records seen confirmed the process and included details of the investigations undertaken and actions taken to ensure people were safe and free from any type of abuse. Many of the concerns had been raised by the service themselves where people had been placed at risk of abuse due to the actions of other involved relatives or health care professionals. The registered manager also explained that recently they had seen a reduction in the number of concerns raised against them.

Records confirmed that care staff received safeguarding training on an annual basis. Care staff were able to explain the different types of abuse people could be subject to and demonstrated an awareness of how these could be recognised and the steps they would take if they suspected someone was being abused. One member of care staff explained, "We have to always keep an eye out for any problems or if there's any medical problems. Always keep an eye out. If I see anything the first thing I would do is record it in the book and let the office know." Another care staff member said, "Yes, protecting the confidentiality and rights of the service user, making sure they don't come to no harm. I'd call the office and speak to the manager." Care staff also understood the term 'whistleblowing' and the steps they would take to report their concerns.

People's care plans listed all risks associated with their health and social care needs. Risk assessments detailed the identified risk, how the person was to be supported to reduce or minimise the risk and the people responsible for supporting the person with the risk. Identified and assessed risks included, falls, fire, behaviour that challenges, moving and handling and risks associated with specific health care conditions such as diabetes and epilepsy and certain high-risk medicines. The service also completed a comprehensive environmental risk assessment which identified any potential risks within the person's property and surrounding environments so that people and care staff allocated to work with the person were alerted to any identified concerns and kept safe and free from harm. Risk assessments were reviewed on a six-monthly basis or sooner if any significant changes had been noted.

Recruitment processes in place were thorough and comprehensive. The service carried out a number of checks to ensure that only care staff assessed as safe to work with vulnerable adults were recruited. Checks undertaken included proof of identity, right to work in the UK, disclosure and barring criminal record checks and references evidencing conduct in previous employment. Care staff were unable to begin work until these checks had been completed.

Recruitment of care staff was a rolling process due to the nature and demands of the service that was being provided. Feedback we received from people and their relatives was that people always received support from a care staff member. However, people and their relatives did say that when their regular allocated carer was on leave, replacement care staff covering them were not always the same each care call. We were also told that communication in relation to lateness and changes was poor. We have reported in detail about these issues under the section of 'Well-led'.

Care staff received training in infection control and how people were to be protected from the risk of infection. Care staff had access to a range of personal protective equipment (PPE) which included gloves, aprons and shoe covers. We observed that care staff were able to come to the office and collect the equipment that they required. Alternatively, the service also arranged for care staff to pick up PPE from in the locality of Waltham Forest on a weekly basis which was more convenient and accessible to care staff working in that area.

All reported accidents and incidents were clearly documented with details of the incident, the actions taken and where appropriate any learning or improvements that needed to be implemented to ensure people and care staff's safety.

Good

Is the service effective?

Our findings

People and their relatives gave mixed feedback about the competency and skills of the care staff that supported them. Much of the negative feedback was related to care staff not having enough time to spend with them and always being in a rush to go to their next care call. People's feedback included, "Yes, in the main. Some are better than others", "They know what to do but I tell them what I want but sometimes they would like to do something different but I tell them" and "The carer is always in a rush so I can't say if she knows what she is doing."

Relatives comments included, "They know what they are doing, they usually send the more experienced carers, they hoist my [relative] and we have sliders to move her as well and they use those fine, they always use their gloves and aprons", "No I don't think so, they often don't know what to do when they get here or do things the incorrect way. There is no general system. Sometimes my husband feels angry and frustrated when they insist on doing things their way" and "I suppose so."

Care staff told us and records confirmed that they had received a comprehensive induction prior to starting work which also included spending some time working alongside experienced care staff before working on their own. Following induction care staff received on-going refresher training in a variety of topics which included, safeguarding, moving and handling, medicines, MCA and DoLS. Training delivery was a combination of face to face and online. Care staff confirmed that training was effective and gave them the necessary skills to do the job. Comments from care staff when asked about the training they received included, "Yes, they do support, like me I did NVQ level 3 in childcare and education and all training in healthcare, they do support very well" and "Yes if you wanted to do your NVQs then they would help you do that."

In addition to training, care staff were also supported through regular supervisions and annual appraisals. Care staff confirmed that supervision support was regular and that it gave them the opportunity to discuss any concerns or issues they may have. One care staff told us, "Yes, I do think it is effective. I've had my six-week supervision." Another care staff said, "Yes, every six months, yes, it's quite open and informal you'd be silly not to use the opportunity to say what's on your mind."

The service ensured that people's care and support needs were always assessed before a package of care was determined and delivered. Assessed areas of need included personal care, preferences in relation to male or female care staff, likes and dislikes, nutritional needs and continence support. This information was used to create a comprehensive care plan which gave care staff clear guidance and information on the person's needs and how they wished to be supported.

Supporting people with their nutrition and hydration needs was only provided where this was an identified need and formed part of the commissioned package of care. Where the service did support people with preparing meals or heating up pre-ordered ready meals, people and their relatives confirmed this to be the case. One person told us, "It's either toast or porridge, alternate days. It makes it easy for me and I know exactly what I am having. Lunchtime they [care staff] do a roll or sandwich, whatever I want. They make me fruit salad, mint tea and cranberry juice. I always have water on me. They leave me cranberry, tea and water." Another person said, "They do my meals but it's what I say, they microwave them but it's not just ready meals, they do veg and whatever I say in it." Care plans noted information about people's dietary requirements. This included specific information about any cultural or religious requirements, likes and dislikes.

Daily records and observations were noted by care staff at every care visit. Information recorded included the tasks undertaken, whether the person had been supported with their medicines and what the person had eaten or drank. Where significant observations or concerns were noted by care staff this was also recorded and reported to the office so that appropriate action could be taken. This included referrals to a variety of healthcare professionals to ensure people received the appropriate care and support. People told us, "The carers would phone my family if I was poorly I think" and "They check on me and if they think I need to ring the doctor then I do it." Feedback from relatives included, "Yes some of the regular carers do notice changes and its discussed between me, my wife and the carer" and "They try to ask relevant questions and recently mum had a swollen foot and reported it to me."

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. Services providing domiciliary care are exempt from the Deprivation of Liberty Safeguards (DoLS) guidelines as care is provided within the person's own home. However, domiciliary care providers can apply for a 'judicial DoLS'. This is applied for through the Court of Protection with the support of the person's local authority care team. There were no people using the service that were subject to a judicial DoLS. We checked whether the service was working within the principles of the MCA.

People, where possible, had consented to the care and support that they received. Where people were unable to consent or sign, the reasons for this had been clearly documented and where appropriate people's relatives had signed confirming their involvement in the care planning process. We saw that where people lacked capacity to make decisions, the service had completed a mental capacity assessment and best interests decisions detailing the specific decisions that the person needed support with. However, capacity assessments and best interests decisions were not always consistently seen in all care plans especially where the person was noted to lack capacity. We highlighted this to the registered manager and operations manager who confirmed that they would address this.

Care staff we spoke with demonstrated an understanding of the MCA and how they were to support people in line with the key principles of the act. Care staff described giving choice and always asking for consent when supporting people. One member of care staff explained, "It's what a service user can do for themselves, if they have any problems we report it, it's how they can look after themselves, if they don't know that they have a mental illness then we can get it checked out." Another care staff told us, "Be patient with the people who have dementia. Be aware of their understanding and listen to them. The more you work with them you learn more and more, I am a patient person."

Good

Is the service caring?

Our findings

People and their relatives told us that care staff were kind and caring. However, some comments received were not so positive as both people and relatives felt that care staff did not have the time to be caring and were always in a rush. Comments from people included, "They are. I might be upset over something I've seen on TV and they always say 'we will make sure you are okay before we go', and 'don't worry, we will help you'. I know who to turn to", "Some staff are alright others well, they are rushing so what can you expect", "There are a couple of nice carers and we have a bit of a laugh but they are too busy to stay long", "I think they do their best in the time they have" and "Yes, they are nice enough."

Feedback from relatives included, "She brings him fizzy water when he wants some. It's above and beyond", "I think so. Some carers take the time to listen to my husband as he has a communication problem", "They are very good with [person] we see them with her and they are fine", "No, I don't think they are caring, they just do the job because they have to" and "I can't say, they are not here long enough."

Care staff described how they built positive and caring relationships with people. Care staff told us that they had established relationships based on trust and understanding. They supported people as if they were supporting a member of their own family and ensured people's involvement at all times. Comments from care staff included, "To be supportive and caring, understand them and patient with them", "By listening to them. See if they understand or not. Read the care plan and see what they like and dislike" and "It all depends on the client and what they want."

People and relatives confirmed that they were involved in the planning and delivery of their care. People told us that care staff did listen to them and supported them according to their preferences and wishes. One person told us, "They understand what I want. They do listen, they jot everything down." Another person said, "Yes I was involved in the discussions about the care package." A third person commented, "Yes I have a Care Plan and I helped when it was written." Relatives told us, "Yes I had input in the initial care plan with my wife" and "Yes, questions were asked about what support we needed."

People and their relatives told us that care staff were respectful of their privacy and dignity and were able to give us specific examples of this relating to personal care which included, "We have the curtain pulled in the room. They do the top half first, or the bottom half. It's all covered up quickly. Once each part is done, they go on to the next part" and "They do ensure the door is closed when I am showering, especially when my daughter in law is on the premises." Care staff were also able to explain how they supported people to maintain their privacy and dignity. Feedback included, "If they are bed ridden make sure their clothed properly. If the door is shut knock before go in", "Never talking about clients with any other members of staff if they go hospital, if they get changed go into their room for privacy" and "By giving them a choice, not invading their personal space, making sure privacy is always given and letting them take the lead in certain tasks that are being done."

Staff understood people's needs in relation to equality and diversity and that each person was different and possibly had different needs and requirements due to their religion, culture or sexual orientation. Care plans also detailed people's needs and requirements in relation to their cultural and religious beliefs. Care staff told us, "I will have chat with them to understand their culture and religion and respect their beliefs", "Me not being from this country I would want others to respect me and I do the same to them. For example, some service users come from the Caribbean and have the same culture as me so it is easier for me", "Respect that everyone has different views and religions and not to make fun of it, respecting people" and "People's culture and diversity, we are looking after many people, we maintain their culture for how they want to dress and eat. That is where we have to give them the preference. Then we put our culture aside and then we have to listen to them and their culture. Some cultures don't eat certain types of food."

Good

Is the service responsive?

Our findings

At the last inspection in April 2017 we found that the service did not always document the action that had been taken to learn and improve the provision of care following complaints that had been raised by people and their relatives. We also noted common themes emerging from the complaints that were raised which included lateness, poor communication and the second care staff not arriving for the person's care when the package of care required two care staff to attend at each call.

At this inspection we found that the service had made improvements to the way in which complaints were investigated and responded to. However, people and relatives feedback still suggested that issues with communication and lateness remained and that even though they complained, improvements had not been noted.

The provider followed their complaints procedure when dealing with each complaint that was received. Each complaint had been recorded with details of the investigation, actions taken, improvements implemented and the responses to the complainant clearly documented.

We asked people and their relatives if they knew who to speak with if they had a complaint and if their complaint was appropriately dealt with. Feedback we received was mixed with some people and relatives telling us that they were happy with the way in which their complaints had been dealt with other stating their dissatisfaction. Comments from people included, "I would probably speak to [care manager] first and then if it needed to go higher, to [name] or the manager. I haven't made any recent formal complaints", "I phoned to make a complaint about a member of staff and she didn't come back. I was happy they sorted that", "I complained but they [office] weren't interested", "I made a complaint about carers coming late all the time and they listened but nothing has changed", "I complained to the office about some things I wasn't happy with and they ended up going back at me and making me feel like it was my fault." Four people told us they would not know who to speak with to raise any concerns.

Where concerns have been noted with communication and lateness and the lack of improvements in these areas, we have reported on this further under 'Well-led'.

Care plans were person centred and detailed and gave clear direction and guidance to care staff on how the person wanted to receive their care. Personal, social and physical profiles gave comprehensive information about the person which included life histories, likes and dislikes, hobbies and interests and important information about their care. Information also included people's preferences about whether they wanted male or female care staff to support them. This information enabled care staff to care staff to understand people's needs and provide care that was responsive to those needs. Care plans were reviewed on a six-monthly basis or more frequently where concerns or changes were noted. One relative told us that the service had been very responsive to the person's changing needs and told us, "They are very flexible. If we need to change something for [person] say at weekends, they will always accommodate it if they can."

Care staff told us that care plans were available in the person's home and that they followed these to ensure people received the care that they required and that was personalised to them. One care staff told us, "I go through the care plan so whatever is written in there that is what I do for them." Another member of care staff explained, "Care is tailored towards the needs of that person each individual is different, we tailor his or her needs to that individual." A third care staff said, "Because there is a care plan I read the care plan if there are any changes I let the office know. For instance, the service user that came from the hospital there's only 30 minutes for him but I spend more time than that, they [management] say they will speak to social services or make someone come and reassess the person."

Care staff demonstrated a good awareness of how they supported people to promote and maintain their independence. Examples included, "I try to encourage them to do everything themselves of what they can. Be beside them and watch, if they can't (do it) I will do. Encourage them to do things themselves", "Asking if they can do something, not assuming that they can't, do not take over" and "If I see that they can wash their face etc. I try to let them do it by themselves. I have to get to know them so I can see what they are able to do and what they can't."

Requires Improvement

Is the service well-led?

Our findings

At the last inspections in April and September 2017 we found multiple issues and concerns around the safe administration of medicines and poor management oversight of the quality of care people received. During both the inspection the service continued to be in breach of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager and provider were issued with warning notices following the inspection in April 2017, requiring them to be compliant in the safe administration of medicines and improving the governance and quality of the care people received. At this inspection we found that the service had made significant improvements in ensuring people received their medicines safely, the quality of care was regularly and robustly monitored and where issues were identified these were addressed.

The registered manager and provider had implemented several checks and audits since the last inspection which enabled them to identify issues such as gaps and omissions in recording of medicine administration, quality of care and ensuring appropriate documents such as risk assessments had been completed where required. Checks and audits included monthly medicine management audits, staff file audits, care plan checks, spot checks, telephone monitoring and home visits. We saw documented evidence of these checks which included details of the issues identified and the actions taken to resolve and implement improvement plans where necessary.

The registered manager explained that management oversight was held on the computer accessible by all senior managers. The registered manager and operations manager had spreadsheets in place which gave an overview of the audits completed and the issues identified so that this could be monitored and followed up where required. This was a working documented which needed to be completed by all senior manager responsible for completing specific checks and audits to ensure checks in specific areas did not get missed. The spreadsheet also included information relating to dates people's care required review, supervisions and training due.

Feedback from people and their relatives at the previous inspections in April and September 2017 identified late calls as an issue. During this inspection we found that this continued to be a concern. Comments from people about lateness included, "They don't let you know if they are running late. One day they came at 8am and not 7am. The office did not ring. The office is terrible for that [not ringing]", "Not really, not all carers arrive on time. Often in the morning the visits can be between 7am until 10.30am. I have complained to the office about lateness but nothing changes" and "One carer turned up at 6am. I don't want a call at 6am and another one came at 6.40am, that's awful. It's all very erratic, another one came at 8.30pm and at 9pm to give me my tea, well I don't want my tea that late, so I can't say they are on time because I don't know when they are going to come." Relatives feedback included, "They are meant to be here to help my relative up in the morning but sometimes they are not here until lunchtime", "Sometimes no and I often don't know when the carer comes and no I don't know who to contact" and "We don't have a fixed time. Morning call can be 8am to 10am and lunch time 10am to 12pm. We have a name in the folder to contact when carers are late."

In addition to lateness, people and relatives also complained that the communication from the office was quite poor and that people and their relatives could not always get hold of anyone at the office. Phones on occasions did not always get answered and even though messages were left, people and their relatives were not always called back with a response to their queries or complaints. People told us, "They normally do ring back during the day, but sometimes it's very busy and you have to keep ringing before it's answered. Out of hours, I have left messages quite a few times. They don't always ring back. I have to ring again. Sometimes you don't get a phone call back", "If they can't be on time, they are not well led" and "In the whole I think they do a good job with the staff and the challenges they have, but it could be better." This feedback was given to the registered manager and operations manager who gave assurances that improvement plans would be put in place to address this issue.

At the last inspection we found that the service had failed to appropriately manage the rotas to allow sufficient travel time between calls and did not consider the distance between each call, despite this being previously identified. During this inspection we found that although five to ten minutes travel was allocated this did not always take into account the mode of transport to be used by the care staff which could mean that the travel time would not be sufficient if care staff were using public transport or were walking.

Care staff told us, "No, no, (travel) like a lunatic. You probably have five minutes to get in between somewhere. It's a bit hectic. Some of them are not situated close to each other. It takes 15 – 20 minutes sometimes to get between calls, some you have a three-hour gap in between so you're just sitting around, so it kind of varies", "Yes, we have travel time but we have no pay for it. We get five minutes between in each job. I'm 75% on time to see service users" and "No, no way. They give five minutes to travel and sometimes the houses are not walking distance, sometimes I'm more than half an hour late."

The service used electronic monitoring systems which allowed the service to track and monitor care staff locations as care staff were required to log in and out at their visits using a telephone system. If a staff member had not logged in or out an automatic alert was sent to the office within 30 minutes and office staff would follow this up. If a person was supposed to be receiving medicines at the visit, the alert of a care worker not arriving was sent to the office after 15 minutes. Out of hours, the alert would be sent to the on-call person's mobile telephone. At previous inspections this system was only used in the London Borough of Waltham Forest but as of July 2018, the system had been implemented in the London Borough of Enfield. The introduction of the call monitoring system had seen a reduction in late and missed visits.

We recommend that the provider consider further methods of improvements in ensuring care staff are allocated appropriate travel time between care shifts, which takes into account modes of travel, to ensure people receive care and support at their preferred time.

People and their relatives did not really know who the registered manager was due to the size of the service, but had more contact with the care co-ordinators and care managers allocated to the management of their package of care. People and their relatives confirmed that they were regularly visited by staff who came and "asked questions" and "asked if they needed anything." People and their relatives also confirmed that they remembered receiving and completing satisfaction surveys in the past which gave them the opportunity to engage and give feedback about the service they received. The last survey was completed in August 2017. Feedback about the care and support people received was positive with issues around timekeeping and communication emerging as common themes. Following the survey a letter explaining the result and the actions the service planned to take to make the required improvements was sent to all people and their relatives.

Office and care staff were positive about the support that they received and they told us that morale had much improved over the last few months. One staff member told us, "Up and down but improving. We had a different manager from another branch bump up things a bit more. I think for the past years we have been going down. We are improving. For people and carers. Good carers are very important." Another staff member said, "It's much better than when I started. Its improved. More communication, more training, carers more involved. I can see we have improved much. We have very good carers." One care staff said, "At the beginning no one was listening. Now they changed a lot, and they listen to my view."

Care staff told us and records confirmed that staff were supported through a variety of processes which included supervisions, appraisals and team meetings. Topics discussed at team meetings included, medicine administration, improvement plans, team work and daily recording. Discussions were also held around relevant issues such as improving the service around communication, missed visits and travel time. Care staff meetings were also held out in the field in convenient areas for care staff to attend to promote attendance.

The registered manager told us that they worked in partnership with the local authority by attending provider meetings and training sessions where providers from the locality were invited to engage with the local authority and each other to learn and share experiences and practises. In addition to this the service also engaged with social workers, district nurses, occupational therapists, day centres and the hospital discharge team to ensure people received the appropriate care and support that they required.