Westminster Homecare Limited

Care in the Home

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Good

Overall summary

This inspection took place on 21, 23 and 27 July 2015 and was announced. Care in the Home provides personal care to people living in their own homes in Gloucestershire. They were providing personal care to 109 people at the time of our inspection.

There was a registered manager in post. 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.

People's care records were not being updated to reflect changes to their health or well-being and to reflect the care staff were actually providing to them. Some people's care records were not being reviewed each year. The absence of accurate, complete and contemporaneous records for people could potentially lead to inappropriate or poor care being provided.

People's care records provided an individualised account of how they would like their personal care to be delivered and by whom. Their preferences, routines and levels of independence had been discussed and agreed with them or their legal representatives and were documented for

Summary of findings

reference by staff. Staff had a good understanding of people's backgrounds and people important to them. They took account of people's disabilities or sensory needs when delivering their care. People had a positive relationship with the staff supporting them and said it was really important to have the same staff attending to their needs. They recognised at times this was not always possible and were informed if new staff would be visiting them. When staff were running late, people said they were mostly informed of this. The registered manager closely monitored if any visits had been missed and took action to prevent this happening again. People knew how to make a complaint and were asked for their feedback about the service they received as part of the quality assurance auditing system.

Staff were supported to develop the skills they needed to support people. The recruitment process made sure all checks had been carried out before they started working with people. During their induction they attended training, shadowed staff and completed open learning. Their knowledge was tested through questionnaires and observation of them supporting people confirmed whether or not they were competent to carry out their duties. A training programme made sure staff kept their skills and knowledge up to date and could develop professionally with national qualifications. Staff received individual support through meetings with seniors and said the registered manager was open and accessible to them for support and discussion. Systems were in place for advice or support out of working hours or in emergencies. Staff had a good understanding of how to keep people safe and to report suspected abuse. Staff achievements were recognised with a carer of the month award.

The registered manager was supported by senior carers and office staff to arrange, schedule and monitor visits to people and to support staff. Lessons were learnt from missed visits, complaints and feedback from people to improve the service. The registered manager recognised the challenges of keeping a consistent staff team and had plans to improve their working conditions and so the service provided to people. Westminster Homecare monitored the quality of service provided through their quality assurance audits and the registered manager was addressing their improvement plan. The registered manager worked closely with social and health care professionals and local providers to deliver a service which reflected current best practice and legislation requirements.

We found a breach 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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People were protected from the risks of abuse or possible harm by staff who had a good understanding of safeguarding procedures. People were supported to take risks in their day to day lives whilst reducing any hazards to keep them as safe as possible.

Robust systems were in place to make sure new staff had the competency, skills and character to meet people's needs. On going recruitment of new staff made sure there were sufficient staff to meet people's needs.

People's medicines were administered as safely as possible.

Is the service effective?

Good

The service was effective. People were supported by staff who had the knowledge, skills and support to meet their individual needs. Staff had the opportunity to complete training required by the service as well as access national training to support their professional development.

People's capacity to consent to their care and support was assessed in line with the Mental Capacity Act 2005 and decisions made in their best interests when needed.

People were supported to have a diet which reflected their individual needs and preferences. Staff helped them to stay well, recognising changes in their physical health and liaising with health care professionals if needed.

Is the service caring?

Good

The service was caring. People were supported by staff who understood their needs and treated them with warmth, kindness and patience.

People were given information about the service they received and asked for their views about what they wanted.

People were treated respectfully and with dignity. They were encouraged to be independent in their day to day lives, to either maintain, regain or learn new skills.

Is the service responsive?

Requires improvement

The service was not always responsive. People's care records had not always been changed to reflect their needs when they were unwell. Some people had not had reviews of their care for some time.

People's care records were individualised and reflected their preferences, routines and their levels of independence.

People knew how to make a complaint. Learning from complaints resulted in improvements to the service provided.

Summary of findings

Is the service well-led?

Good

The service was well-led. People's views and feedback were sought and used to make improvements to the service they received. There was a culture of openness and transparency. Apologies were given to people when mistakes were made.

The registered manager was accessible and available to people and staff, recognising the challenges of the service and looking for ways of making it better.

Quality assurance systems monitored people's experience of care and were used to drive through improvements.

Care in the Home

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.

The inspection took place on 21, 23 and 27 July 2015 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 in. One inspector and an expert by experience carried out this inspection. 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 expert's area of expertise was older people. 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. Questionnaires had been sent to people using the service, staff and social and health care professionals. We also reviewed information we have about the service including notifications. A notification is a report about important events which the service is required to send us by law. We had also received information from Healthwatch.

As part of this inspection we visited five people using the service, made telephone contact with 14 people and received questionnaires from 20 people and three relatives. We spoke with the registered manager, a representative of the provider, two senior staff and eight care staff. We reviewed the care records for six people including their medicines records. We also looked at the recruitment records for five staff and their training records, quality assurance systems and health and safety records. We observed the care and support being provided to people. We received feedback from five community professionals.

Good

Is the service safe?

Our findings

People told us, "I feel safe with the staff visiting me", "Yes, I feel quite safe with them" and "It helps to have the same staff". People who responded to our questionnaires said, "My relative would be well aware if she wasn't receiving good care" and "Mum is very comfortable and secure with them". In response to the provider's annual survey one person commented, "I was quite wary of having strangers into my home, I feel more comfortable now I know them" and another person said, "I feel safer because of this service". People had copies of the local safeguarding procedures in their care files in their homes providing information about how to recognise and report abuse with contact details.

People were supported by staff who had a good understanding of their roles and responsibilities with respect to recognising, recording and reporting suspected abuse. Staff confirmed they had completed safeguarding training for adults and children and their knowledge was checked through workbooks and questionnaires. The provider's safeguarding policy and procedure did not provide local contact details of the local safeguarding authority although posters were displayed in the office with this information. The registered manager said she would make sure these contact details were added to the policy. The registered manager talked through a safeguarding incident and the action they had taken in response. They had alerted the relevant authorities and notified the Care Quality Commission.

People had occasionally reported missed visits to the office. The registered manager kept robust records showing investigations into why visits had not taken place. She had responded individually to people apologising and explaining the reasons for the missed visit and identifying any action being taken to prevent this happening again. For example, retraining staff organising the visits or reviewing the way visits were scheduled. There had been 11 missed calls between January and June 2015. Most had been due to human error. When the on call staff were alerted to missed visits they either carried them out themselves or arranged for staff to cover. One person said they had decided to cancel the visit because they had managed on their own. Another person told us, "No, they've never missed me and they would ring if they couldn't come. They're very reliable people".

People confirmed they had not had any accidents or incidents. This was verified by staff. One minor accident had been recorded. Staff had been prompted to make sure any accidents, incidents or near misses were recorded and the office was informed, due to the low level of accidents reported. Staff had also been reminded in training of the recording and reporting process. The provider had highlighted this and indicated this was an area for further monitoring by the registered manager.

People were kept safe from the risks of potential harm. Individual risk assessments highlighted any known hazards to them, such as previous falls or slips, and detailed the action taken to minimise these. When people needed specialist equipment or adaptations in their home these had been provided after consultation with an occupational therapist. Staff were prompted to alert the office to any changes in people's well-being so that action could be taken to keep them safe. People's home environment had been assessed for any hazards or risks to them and staff.

Staff understood the whistle blowing procedure and were confident any concerns they might have would be listened to and the appropriate action taken. Investigations into concerns, safeguarding incidents and missed visits were robust and there was evidence action had been taken to prevent them happening again.

A business continuity plan outlined action which would be taken in an emergency such as utility failures or staff shortages. There was an out of hour's service which people and staff could call if they needed help or advice. This was monitored by the registered manager to check for any trends or themes emerging such as missed visits, refused visits by people or refusals of care.

People were kept safe from potential harm by robust recruitment and selection processes for new staff. Each new staff member completed an application form. Some people had gaps in their employment history. These had been highlighted during an audit of their records and a full employment history had then been provided. There was evidence of improvement in this area of the recruitment process, with any gaps being discussed during interviews. Checks had been carried out with previous employers and where people had worked with children or adults the reason they left this employment had been clarified. The authenticity of references was validated through telephone calls to referees. Prior to employment Disclosure and Barring Service (DBS) checks had been received. A DBS

Good

Is the service safe?

check lists spent and unspent convictions, cautions, reprimands, final warnings plus any additional information held locally by police forces that is reasonably considered relevant to the post applied for.

People said there were sufficient staff to meet their needs although for some people they did not always have the same staff visiting them. Staff said last minute sickness was always a challenge to cover but they managed this whether through taking on additional visits or seniors helping out. People commented, “They let me know if they are going to be late” and “They are occasionally short staffed, so I don’t always have the same staff”. Staff confirmed the appointment of new staff currently going through induction which would help to alleviate this. The registered manager said they had reviewed the structure of teams and tried wherever possible to have staff working in the same area with the same group of people. This not only helped with continuity of care but also the logistics of travelling time for staff to get from one visit to another. She said new contracts were being put in place for staff to work set shifts so there would be more flexibility for care co-ordinators when scheduling and planning visits to people.

Some people needed help to manage their medicines. Where this was the case, they had given their permission for staff to either prompt them or administer their medicines. Records clearly stated what medicines they were taking and how people wished to have them. Staff were observed asking people how and when they wanted their medicines and making sure they had been taken. Medicine administration records were completed by staff after people had taken their medicines. One person told us, “They know that I know very well what medication I need to take but they always watch me while I take them”. The registered manager discussed the number of medicine errors reported by staff. These included missing signatures on medicine records or missed doses. In response to the high numbers of errors reported new medicine administration booklets had been produced which provided additional guidance for staff and a clearer way of recording administration of medicines. Staff had completed refresher training to introduce these new recording systems. Senior staff carried out observations of staff to check their competency and medicines were audited by the provider as part of their quality assurance process.

Good

Is the service effective?

Our findings

People said staff were "All good, all perfect, there are no problems with any of them" and "Girls are really good and do their best". One person commented, "I know they have training sessions because they have told me". Staff confirmed they had access to a range of training to keep their knowledge and skills up to date. A trainer had been appointed to provide courses and training in line with the provider's schedule of mandatory training. They were also able to deliver training which could be designed to reflect the needs of people being supported. For example, they planned to deliver end of life training and dementia friends training. They had also reviewed their approach to the administration of medicines due to a high number of errors and all staff were completing medicines refresher training. The trainer was also able to work alongside staff to promote best practice.

The new care certificate had been introduced to new staff as part of their induction, promoting a blended approach to training through classroom courses, open learning, shadowing staff and then completing questionnaires. Observation of staff carrying out their tasks was a vital part of this and senior staff were being trained to carry this out. The provider information return (PIR) stated, "We are committed to ensuring provision of appropriate training to all staff in order that they have the opportunity to excel in their performance and advancement." Staff confirmed they were supported to achieve national qualifications and for some this had resulted in promotion within the service. Individual training records were kept electronically and monitored by the registered manager to make sure staff had access to refresher training when needed.

People benefitted from staff who said they were supported well in their role. They confirmed they had individual meetings with senior staff to discuss their roles, responsibilities and training needs. These were scheduled every six weeks or sooner if needed for example to offer additional support or review problems with their performance. Staff were observed supporting people in their homes as part of this process. They also had annual appraisals to assess their performance. Staff said communication with the office and senior staff was really robust. They said they could phone, text or drop into the office. Senior staff said all staff had to visit the office at least once a week to drop off their timesheets and they were able to check on their well-being face to face. Staff meetings were held each month and minutes kept for staff unable to attend. Discussions focussed on such issues as the new care planning systems, medicines errors and training.

People's capacity to consent and make decisions had been assessed in line with the Mental Capacity Act 2005 (MCA). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. Where people had fluctuating capacity to consent to their care this was recorded. Any decisions which needed to be taken in people's best interests were to be recorded on a new consent record being introduced. A best interests decision is made when people are assessed as not having the capacity to make a decision and involve people who know the person well and other professionals, where relevant. Records confirmed when people refused to receive aspects of their support. Most people had consented to their care, signing their care records and giving permission for staff to administer their medicines. People were encouraged by staff to make choices and decisions about their care and support. A new record was being put in place evidencing people's capacity to make decisions and whether they had a lasting power of attorney (LPA). The registered manager said she would make sure she obtained evidence of the lasting power of attorney and whether this was for personal welfare, property and affairs or both.

Some people needed help and support to manage their diet and fluid intake. Their care records clearly stated their specific needs such as diabetes, allergies or whether a soft diet was needed. People were offered choice about what they had to eat and drink. Staff did not make assumptions because a person usually had a cup of tea they always wanted the same drink. People were asked about their preferences and the way they wished their food and drink to be prepared. For example, hot or cold milk with their cereal or the temperature of their food.

People were supported to stay well. Staff monitored their health and if they noticed any changes, with their permission, they alerted staff at the office and the person's relatives or GP. Staff said community nurses and GP's left messages for them if people's care had changed or they needed to do anything differently. They said they informed

Good

Is the service effective?

the office so other staff could be kept up to date as well as making a note in their daily records. Staff helped people to prepare for hospital or outpatient appointments. People said visits could be re-arranged so they could keep these.

Good

Is the service caring?

Our findings

People commented, “They do a wonderful job”, “I get on with them very well, we always have a laugh” and “I’ve had no problems at all with the carers”. A social care professional told us, “The staff have a good rapport with a particular service user. They were polite and focussed on the support they provided”. Staff were cheerful and patient, helping people with warmth and kindness. People had positive relationships with staff chatting about their lives and enjoying a laugh together. Staff took their time; they did not rush people taking the lead from people and how they were feeling. Although as one person told us, “The girls are behind before they start, they don’t always have time for a social chat”.

People’s preferences for how their care and support was provided were clearly identified in their care records. One person said they had been asked if they had any preferences about the gender of staff delivering their personal care. They had said they would like female staff only. Their care records reflected this and they said their wishes had been respected. Staff had a good understanding of how to support people with sensory needs. When supporting a person with a visual disability they talked through what they were doing, explaining each action and acknowledging the impact of noise and keeping this to a minimum. Staff supporting a person with a hearing disability spoke clearly and loudly, kneeling down to their level so the person could see their lips when speaking. People with a physical disability had a range of equipment to promote their independence and staff encouraged them to use walking aids.

People’s health was monitored by staff who reassured them when unwell and helped to reduce any pain or discomfort. Staff showed concern for people’s well-being offering advice or assistance and escalating any concerns they had with the relevant community professionals. Staff showed a good understanding of people’s background, their history and their personal support systems. They listened to people and responded to them appropriately whilst getting on with the task in hand. Staff confirmed they had a “more person centred approach”, “enabling people, being patient and responding to their individual needs”.

People confirmed they could have a copy of the rota letting them know who was scheduled to visit them each week. They said some of these shifts were unallocated due to sickness or annual leave. People liked to have the same staff visiting them, who knew and understood their care. One person said, “I don’t know who is coming to me until they arrive” and another commented, “It’s all changing this weekend from my usual ladies to two gentlemen”. In response to our questionnaires 25% of people said they had not always been introduced to staff. People said senior staff visited them to talk about their care needs and to see if any changes needed to be made. People were also telephoned to seek their views about the service provided and to check if any changes were needed. People had information in their homes about the service to be provided and about advocacy services available to them.

People were treated respectfully and their privacy was promoted. In response to our questionnaire everyone said they were treated with dignity and respect. People told us, “Yes, they treat me with respect. I’ve no reason to complain at all” and “They always treat me with dignity and I’ve never felt that they did not want to do it”. Personal care was delivered in private and staff sought permission before carrying out any tasks. People were encouraged to be as independent as possible. Their care records documented what they could do for themselves and what they needed help with for staff reference. Staff were aware of the importance of enabling people to do as much as they could for themselves, patiently prompting and reassuring people. A person said, “They always make sure I’m comfortable and okay before they put the lights out and go”. People’s care records prompted staff to “maintain independence and dignity” and people’s daily records indicated this had been done. Feedback to the provider included, “Mum is treated with great respect and compassion by her care workers.” The provider information return stated, they treated people with “dignity, understanding people’s differences” and they helped people to “regain skills or to learn new skills” to “make a difference to people’s quality of life”.

Requires improvement

Is the service responsive?

Our findings

People's care records did not always reflect their changing needs and the care they were actually receiving. For example, when a person became unwell, their care records were not changed to reflect this and staff relied on verbal communication from the office to make sure they were kept up to date. People's daily records indicated what the changes had been, for example poor skin condition had led to a pressure ulcer. This was treated by community nurses who recommended bed rest and advised staff on the appropriate course of treatment to be given. The person's care records stated their skin condition was good and not at risk of breaking down. No temporary care plan was in place to provide staff with prompts about the changes in their care routine. Another person had collapsed due to the effects of inadequate hydration but their care records did not reflect this risk. Three people's care records had not been reviewed for between 13 and 21months. Senior staff said they had some overdue reviews but were working to rectify this.

This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans gave staff an individualised description of how they wished their care and support to be provided. Step by step guidance prompted staff about people's preferences, routines and what they could do for themselves. Staff said they ensured people retained control of how their care was delivered by checking with them at each visit how they wished their care to be provided. People's aspirations such as "maintaining my independence and feeling safe and secure" and "to maintain my independence so I can remain at home" were highlighted in their care records. The registered manager described new care plans which were being introduced which would provide greater detail than those in use, such as more information about people's background and history. They would also provide in depth information about people's sensory and communication needs.

The different needs of people living with dementia or people with some kind of sensory loss were understood by staff and considered when they were supporting people with their care. For example, gently prompting people to eat or drink when they thought they had already done this or recognising loud noises disturbed people with a visual disability and warning people when these were likely to happen, such as switching on an electric fan.

Some people had reviews with senior staff to discuss their on going needs. Their care records had been changed to reflect this. One person commented, "I've recently had a review and I do have a say in my care". Other people could not remember being involved in discussions about their care. People said they would call the office if they needed additional visits or wanted to cancel visits. One person explained they no longer needed a tea time visit because they could manage to do this themselves. They said if they felt unwell, staff would always make them a sandwich during the lunch time call for later in the day. Another person said, "I can discuss my care with them. I listen to what they have to say and they listen to me".

People said they could contact the office to rearrange visits to fit in with their social arrangements and they would help wherever possible. Care records identified contact details of relatives and friends of people. Staff had knowledge of people's social networks and how important these were to people, checking with them these were still in situ.

People told us they had no complaints about the service they received. They had information in their care records which guided them how to make a complaint to the service, the provider or other organisations. People commented, "I can always call the office if I have a problem", "I'd have no problems in making a complaint, they're very efficient" and "I know how to complain and would not be afraid to do so". The provider information return stated, "We promote complaints/suggestions as part of our continuous improvement strategy." The service had received three complaints during 2015 which they had investigated and responded to people offering an apology when needed. People had been told what action had been taken in response to such concerns as missed visits and care practice. Wherever possible the registered manager met with complainants face to face to discuss their concerns and to give them feedback. The registered manager described how they had learnt from complaints and taken action to prevent them from reoccurring by either changing the working practice of staff or retraining staff.

Good

Is the service well-led?

Our findings

People told us, “The girls are good, they look after me” and “They go over and beyond their official duties”. People had a range of ways in which they could give feedback about the service they received. Telephone checks were used by the registered manager and her team to assess the quality of service provided. These were in addition to annual surveys sent to people and their relatives as well as staff and community professionals. Feedback was sent to people, after the survey, detailing the action taken to improve their experience of care, such as making sure the office called if staff were running late. People confirmed this was happening. People were also asked for their views during reviews of their care. Observation of staff delivering personal care was another tool the registered manager could use to monitor the quality of care delivered.

The registered manager was aware of their responsibilities with respect to their duty of candour to be open and transparent with complainants. Letters expressing an apology were sent to complainants which also clearly stated what action had been taken to address their concerns. The representative of the provider said they were concerned about the lack of accidents and incidents being reported. Staff said they had additional training to remind them what to report and how to report it, but they said there had been no accidents or incidents to report. The registered manager monitored missed visits and complaints to make sure action was taken to address any issues or problems to improve the service. The registered manager was also aware of the Care Quality Commission’s requirements to notify us of significant events and communicating with us when needed.

People said they had contact with the registered manager who they found to be “really good”. Staff described the registered manager as, “lovely, very supportive”, “fantastic and very professional” and said “it is not easy doing this job; she tries to make it better”. The registered manager recognised the challenges for the service as maintaining a staff team and working within their resources. With respect to these, changes were being made to the way in which staff hours were contracted. Some staff would work set contracted hours which would alleviate the problems of unpaid travelling time but also giving greater consistency for staff rounds and visits. Staff said they would raise concerns about poor practice with the registered manager or senior staff and they were confident they would be listened to. Staff described how the registered manager “is easy to talk to” and “will find a way around to help you”. Senior staff confirmed a disciplinary meeting would be held when needed and poor practice challenged with staff being helped to develop professionally through individual support and training. Social and health care professionals said, “The manager was quick to act (in response to a safeguarding concern) and easily available” and “a response to my request for additional visits was both supportive and flexible”.

The provider information return (PIR) stated their mission, vision and values, “to make a difference to people’s quality of life”, were developed with people, their families and staff “to effectively provide person centred support”. Staff confirmed this telling us, “we are more person centred” and “more responsive to people’s needs”. The registered manager was confident the new care plans being introduced would reinforce this.

The registered manager discussed their annual improvement action plan issued by Westminster Homecare and monitored by a representative of the provider. Some actions had already been addressed and others which were being implemented. One action to invite people to a service user forum to increase people’s involvement was planned for September 2015. Quality assurance audits were also completed at monthly intervals by a representative of the provider who was observed checking on recruitment files during our inspection. These audits identified actions reflecting the five key questions we ask.

The PIR highlighted how staff were appreciated and recognised for their achievements. An internal 10 year anniversary award commended staff for their “dedication and commitment” and a carer of the month was nominated by people or staff. Westminster Homecare had been awarded national awards in recognition of the support provided to their staff and their health and safety record. These made sure the organisation kept up to date with national best practice and legislation. Locally the registered manager was part of meetings with other local providers and the local authority to share good practice and changes to local commissioning.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 17 HSCA (RA) Regulations 2014 Good governance An accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user was not being kept. Regulation 17(2)(c)