Westminster Homecare Limited

Westminster Homecare Limited (Norwich)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Westminster Homecare is a domiciliary care service. They provide personal care and support to people living in their own homes. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. At the time of our inspection the service was providing a regulated activity to 88 people.

People's experience of using this service and what we found

There were some gaps in the registered manager's awareness of the organisation and quality of service some people were receiving. Staff did not always display professional, safe and caring conduct when visiting people.

There was not always a positive working culture which included staff and people fully in the running of the service. Staff worked well as a team, but there was some separation between the care staff and office staff in terms of teamwork.

People using the service and their relatives felt that the management team were approachable and felt comfortable to contact them if they had a problem.

There were mixed feelings about whether people and their relatives felt involved in the service and their care, and staff were not always informed about changes in a timely manner.

There were enough safely recruited staff to cover care visits. People who had a consistent group of staff for their visits were more positive than those who received care from many different staff members.

There were systems in place which supported staff to keep people safe from harm.

Care plans contained information relating to risks to people, and guidance for staff to mitigate these. Some further information and guidance around specific risks associated with health conditions would be beneficial.

Where it was included in their care, staff supported people to take their medicines safely. Risks relating to medicines had been fully assessed and recorded in the care plan.

Systems were in place to prevent and manage the spread of infection, including COVID -19.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection

The last rating for this service was Requires Improvement (published 7 August 2019). At this inspection enough improvement had not been made and the rating remains the same.

Why we inspected

This was a planned focussed inspection on Safe and Well-led, based on the previous rating.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Westminster Homecare Limited on our website at www.cqc.org.uk

Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

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Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors and two 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.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave two working days' notice of the inspection visit because we needed to be sure that the provider or registered manager would be in the office to support the inspection. We also needed to request records to review remotely and contact details for staff and people using the service.

Inspection activity started on 28 April 2021 and ended on 30 April 2021. We visited the office location on 29 April 2021.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is

information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection, such as notifications and information received from the public. We sought feedback from the local authority and professionals who work with the service. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with 23 people who used the service and 10 relatives via telephone about their experience of the care provided. We spoke with 10 members of staff including the registered manager and nine care workers.

We reviewed a range of records. This included 10 people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, electronic visit monitoring and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

● At the last inspection, we found that there were not always enough staff to cover visits as required. At this inspection, this had improved and records showed there was a low percentage of late visits, and no missed visits. However, we received some mixed feedback about the competence and conduct of staff.

● Four staff told us they felt new staff were not always fully prepared to meet people's needs on a first care visit. For three staff, they felt this was because they had not always met the person prior to their first visit. Although they shadowed experienced staff and underwent an induction, this did not always involve visiting people they would be delivering care to. A new staff member said, "If I was running the service as well, I would take carers to visit people before going to deliver care to them." They said they felt unprofessional, and that the first visit did not include any extra time to read the care plan. Two relatives and three people said they felt newer staff did not always know what to do. We fed this back to the provider who said they would act on this.

● Most people who used the service had a consistent group of staff for their visits and were more positive about the care they received than people who had visits from many different and new staff members. One said, "I always know who is coming and I am very comfortable with them." Another echoed, "I get the same carers all the time, they stay about 25 mins to half an hour, it's never less than that."

● Four people and four relatives we spoke with told us they felt there were a lot of late calls. However, the monitoring system records showed that over 93% of calls this year were within the agreed timeframe.

● Some staff and people said they did not always have a choice of male or female care staff, and some people felt distressed due to this. However, the provider explained that it was not possible to meet these preferences at all times, and people had been made aware of this on commencing using the service. All other people we spoke with told us they received consistent care staff that they were happy with.

● There were safe recruitment practises in place, including the appropriate criminal record checks, employment history and references.

Systems and processes to safeguard people from the risk of abuse

● There were systems in place which supported staff to keep people safe from harm.

● People we spoke with felt safe using the service. One said, "I feel very safe with them, they are very good and helpful."

● Staff knew how to report concerns and received training in safeguarding. Some staff gave us examples of concerns they had reported in the past.

Assessing risk, safety monitoring and management

● There were systems in place to assess and manage risks to people.
● Care plans contained information relating to risks to people, for example within their home environment, and associated with their mobility such as falls risks. However, in some areas of the care plan, further information and guidance around specific risks associated with health conditions such as asthma and diabetes would be beneficial. We discussed this with the registered manager who said they would review this.
● Staff received training in manual handling and supported people to move around safely. One person said, "Yes, I have my own hoist, and they are all good with it. They handle it with dignity and care."

Using medicines safely
● Where it was included in their care, staff supported people to take their medicines safely.
● Where staff supported people with taking their medicines, they had signed a MAR (Medicines Administration Record) to show this had been done.
● Risks relating to medicines had been fully assessed and recorded in the care plan. This included for higher risk medicines such as blood thinners, and where staff left medicines out for people to take later if needed. Where topical pain patches were applied, there were body maps and records to show when and where on the person.

Preventing and controlling infection
● Systems were in place to prevent and manage the spread of infection, including COVID-19.
● There were individual risk assessments for people concerning COVID-19 which included guidance for staff around how to manage this in the individual's home.
● Staff were provided with additional training around PPE use during the pandemic, and people said care staff wore their PPE safely.

Learning lessons when things go wrong
● The management team took action on accidents and incidents to review risks.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- At the last inspection, there was a lack of oversight into whether staff had completed all the care visits as required. At this inspection, this had improved and there was an electronic call monitoring system in place. There were few late visits and no missed visits this year.
- Systems in place to monitor the quality of service people were receiving were not always effective. One person told us they felt there was a, "Complete lack of organisation." This was echoed by some staff who said they did not always have consistent visits with people who knew them, and there were last minute visits regularly added to their day without consultation.
- From some people, we received negative feedback around staff member's conduct, for example, one person told us staff did not know how to clean up or use the oven, and another told us a staff member had left their toilet dirty after using it. One person said, "I think the staff could do better, like speak to me sometimes, staff will only ask me a question." A relative told us, "[Family member's] walking stick had fallen on the floor, and a carer walked over it without picking it up." Experienced staff, including staff checking new care staff's competencies, did not always display professional, safe, person-centred conduct when carrying out spot checks in people's homes. One member of staff reported they were new, and administering medicines to a person with complex needs; whilst they were doing this a staff member was asking them competency-based questions covering whistleblowing and care delivery scenarios.
- There was not always effective communication to identify and act on concerns. Four people we spoke with and one relative had requested that at least one staff member did not return to them, reasons varying from perceived incompetence to a lack of respect and knowledge of what to do on the visit. However, some people still had these staff return to them, one person said, "I cancel a carer, but they keep putting the carer back; why?" A family member told us, "One carer was a bit stroppy, and I asked the office not to send them again, but they turned up again, so I had to tell them again."
- For areas of service delivery where we received negative feedback, the provider had also received some complaints on which they took action; two formal complaints about the conduct of care staff had been received, individually investigated and responded to by the service in February 2021. Whilst these immediate concerns were resolved, some similar concerns remained at our inspection.
- When we raised the concerns we received about staff conduct, consistency and competence, the registered manager was not aware of these. The last survey had been completed in 2019 with people using the service, and in the meantime, other systems in place, such as monitoring telephone calls to people, had not identified these problems.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● We received mixed feedback around whether there was a positive working culture which included staff and people fully in the running of the service.

● Four staff fed back to us that when they raised concerns or said they were unable to pick up extra work, they received a negative response from the office staff. One said they felt they, "Rubbed them up the wrong way," and another added, "It feels like they get a bit annoyed." However, another said, "[Registered manager] is a good manager, they brought us a present and card from their own money which they didn't have to." A further staff member said they felt the registered manager was, "Lovely and answers the phone straight away."

● Staff worked well as a team, but there was some separation between the care staff and office staff in terms of teamwork; one staff member told us, "We're more likely to call other carers about someone we want to know more about than the office."

● There was not a system in place which identified the above problems within the staff culture, however the registered manager and operations manager told us they would perform a local staff survey as a result of this feedback.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● One family member told us, "The manager apologised to us for some very late calls." Another said, "There is nothing I can think of that they could do better; the office is approachable and they respond appropriately to the needs."

● People using the service and their relatives felt that the management team were approachable and felt comfortable to contact them if they had a problem.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● We received mixed feedback about whether people and their relatives felt involved in the service and their care. One person said, "I always have a meeting about every six months to check on the care plan and if things have changed." However, a family member told us, "They phoned to do a review, but we got nowhere." Another added, "[Staff member] came round to do the assessment, but I haven't heard a dicky bird from them since. I've not had a single call from them."

● Staff gave mixed feedback about whether they felt informed about changes. One said, "I hadn't been told that [person's] visit time was changed from 30 mins to an hour so I thought I was just doing a cleaning visit - nobody made me aware even though I go in most days." Another said, "I don't feel supported by the managers, we have tried and tried to raise concerns but nothing's done, it's not dealt with, they hope we'll just forget."

Continuous learning and improving care

● There had been significant improvements to the service delivery and records since our last inspection, but there remained areas for further improvement.

● The registered manager was not always aware when people had concerns about the service they received, which made it difficult to act on these to improve care.

Working in partnership with others

● Where needed, the service worked closely with other agencies such as social services to ensure people received the care they required. They also worked with other health professionals when required, requesting and following any recommendations.