Westminster Homecare Limited

Westminster Homecare Limited (Cheltenham)

Inspection report

Unit 4, Bamfurlong Industrial Park
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Gloucestershire
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12 November 2019

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Westminster Home Care is a domiciliary care agency. 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 the inspection the service was supporting 44 people, 43 of whom were receiving personal care.

People's experience of using this service and what we found
Systems to protect people from abuse and risk were not always effective. Care visits to people had at sometimes been missed. This had placed people at risk. Some visits were shorter than allocated times which meant some care tasks had not been completed. Where people required two carers to transfer them safely using equipment, these visits were sometimes carried out by one carer. This placed the person and the carer at risk.

Medicines had not always been managed safely. Some people had missed their prescribed medicines administration. Audits to check the safe management of medicines had not taken place which meant any errors would not be identified in a timely manner and put right.

Accidents and incidents had not been accurately recorded therefore the service may not learn from analysing themes and trends.

Staff told us there were not enough of them to cover all care visits. Staff were having to work very long hours to ensure these visits were covered when there was a lack of experienced agency staff.

Staff required mandatory training or refreshers in areas such as safeguarding. One to one supervision, appraisal, competency spot checks and induction reviews were out of date.

Not all care plans had been reviewed within the providers timescales. Quality monitoring of the service being provided and audits had not been completed in a timely manner.

People had care needs assessments undertaken and care plans developed. People told us they had very good regular carers and had built strong relationships with them. Staff told us they enjoyed their work and people were treated with respect and dignity.

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

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 good (published 25 May 2017).

Why we inspected
This was a planned inspection based on the previous rating.

We have found evidence that the provider needs to make improvements. Please see the safe, responsive and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to safe care and treatment, person centred care and good governance of the service, at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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 effective?

Requires Improvement

The service was not always effective.
Details are in our effective findings below.

Is the service caring?

Good

The service was caring.
Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.
Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.
Details are in our well-led findings below.

Westminster Homecare Limited (Cheltenham)

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 one inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. 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. However, the registered manager had been absent from their post and the service for several months.

Notice of inspection
This inspection was unannounced.
Inspection activity started on 11 November 2019 and ended on 22 November 2019. We visited the office location on 11 and 12 November 2019.

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.

During the inspection
We spoke with three people who used the service about their experience of the care provided. We spoke with six members of staff including the operations director, the operations manager the care coordinator, the quality officer, recruitment officer and care workers.

We reviewed a range of records. This included five 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, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with the local authority safeguarding team, the local authority commissioners and other professionals who worked with the service.

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 good. At this inspection this key question has now deteriorated to requires improvement. 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.

Systems and processes to safeguard people from the risk of abuse

- The systems in place to safeguard people from the risk of abuse were not always effective.
- CQC had not received two Notifications (required by law) relating to safeguarding incidences. For example, one incident had been investigated by the service and referred to the local safeguarding authority but should also have been sent to the CQC as a Notification.
- Visits to vulnerable people were missed. One person who lived alone was left at risk due to a missed evening visit. They had not been supported into bed, windows were left open and equipment was left in an unsafe condition. Another person's visit was missed which meant they had not been given a prescribed medicine.
- People had not received their full allocation of time and therefore some support tasks had not been completed. One person had been left without continence protection.
- The local authority flowchart for making a referral was not visible in the office or in the services safeguarding file. When this was discussed with the operations manager at the time of the inspection, it was printed and placed on the notice board.

Assessing risk, safety monitoring and management

- The systems in place were not effective enough to reduce identified or known risks.
- Risk assessments had not been reviewed within the providers timescales and were out of date.
- Risk assessments were generic and not personalised to individual needs. Where people had specific identified risks, such as a high risk of falls, there were no risk assessments completed.
- In addition to this, people's files did not contain a fire risk assessment. Some people were being supported to use paraffin based topical creams, which could be a fire hazard where people smoked.
- People who required two carers to provide support and use equipment safely, had been receiving support from one carer. This meant the person and the carer were at risk of injury.
- We saw records which showed 10 members of staff had not received a spot check of their practice in line with the providers review target date.

Using medicines safely

- Medicines were not always managed safely.
- People did not receive prescribed medicine when their visit had been missed. Some Medicines Administration Records (MARs) observed, had gaps without an explanation.
- People's care plans stated medicines training was to be updated every 12 months in line with the company policy and procedure. Seven staff had out of date medicines administration training.

● Care plans had a template body map in place for charting where prescribed creams were to be administered. However, these were not completed. The MAR charts we observed did not have accompanying body maps to show accurately where prescribed creams were to be administered.
● MAR charts did not have protocols in place for 'as required' medicines such as paracetamol. For one person this meant they were requesting regular daily pain relief which needed to be reviewed by their GP.
● MAR charts had not been audited for several months which meant any errors or gaps had not been effectively investigated or actions taken to minimise errors.

Learning lessons when things go wrong
● Accidents and incidents were not accurately recorded. There was only one recorded accident/incident on file dated July 2019.
● The provider's internal quality audit dated 14 and 15 October 2019 identified 15 instances of accidents/incidents which had not been formally recorded. Care plans and risk assessments had not been updated. This meant actions had not taken place to reduce the re-occurrence of the accident/incident. Themes and trends could not be accurately or effectively identified.
● The action plan requirements from this audit were all stated as 'immediate'. The lack of immediate action being taken suggests that lessons were not being learned.

These areas constitute a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● The service had 13 permanent members of staff and were continually recruiting. Staff we spoke with told us they needed more staff as some were working many extra hours to cover visits.
● The care coordinator told us the service had to use inexperienced agency staff at times. These were agency staff who did not know people's needs as well as the permanent staff.
● Processes to ensure safe recruitment of staff had been followed. The four staff personnel files we reviewed had identity checks, right to work documents, references and a Disclosure and Barring Service check (DBS). A DBS helps employers make safer recruitment decisions and prevents unsuitable people working with vulnerable people.

Preventing and controlling infection
● Care plans recently reviewed contained guidance to staff on hand hygiene and prevention of cross infection.
● Staff had access to and used personal protective equipment, such as gloves and aprons, when supporting people.
● Staff received training in infection control practices and effective hand washing techniques were visible around the office.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff training and support was not sufficient to meet people's needs effectively.
- The operations manager showed us information which indicated seven out of 18 members of staff were out of date on the providers mandatory training. These areas included safeguarding, medicines administration, moving and handling and mental capacity training.
- We saw records which showed 10 members of staff had not received an observed spot check of their practice in line with the providers review target date.
- Three members of staff appraisals were overdue and three new members of staff required a shadowing assessment.
- Staff supervision was inconsistent. The providers policy indicated an annual appraisal and six-monthly supervisions. However, some staff supervision agreements stated three monthly supervision was arranged which had not been completed. We saw records which showed 13 members of staff required a one to one supervision review.

These areas constitute a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People's health and social care needs were assessed prior to receiving support. Local authority assessments were in place where people were receiving funded care.
- Care plans were developed from these assessments to meet identified needs. However, some people's care plans were out of date and required review, which meant people's needs may not have been fully met, particularly if their needs had changed. For example, one person's care plan was last reviewed in April 2018. There was a statement in the care plan; 'this care and support plan will be updated at least annually unless there are any changes in my care which require it being updated sooner'.
- Full oral health care assessments were not in place. This meant people's specific oral health and hygiene needs may not have been met.
- People were supported to access the GP and community nurse services when staff had identified they were unwell.

Supporting people to eat and drink enough to maintain a balanced diet

● People were supported with their nutritional and hydration needs. People were offered choice and encouraged to maintain a healthy diet.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.
● Where people had capacity but were unable to sign their consent to receive care, records stated the document had been read out to the person and consent given verbally.
● The staff we spoke with had knowledge of the Act and enabling people to make choices.
● We saw copies of a registered Lasting Power of Attorney (Health and Welfare) for one person who lacked capacity to make decisions about their care. This meant the process was followed in order for decisions to be made lawfully for this person's care needs.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
- People we spoke with told us they were very happy with their regular carers.
- People told us they had built up caring and trusted relationships with their carers some of whom had been supporting them for many years.
- People told us they were treated with respect and were supported with choices and how they preferred their care to be provided.
- Staff we spoke with talked passionately about the care they provided for people and how much they loved helping the people they visited. Some staff told us they felt people were like family members and they looked after them as though they were family.
- Care plans we reviewed had details about the person's life history, family and interests. This helped new staff to converse and build relationships.

Supporting people to express their views and be involved in making decisions about their care
- People and relatives had been involved in their care needs assessment and development of their care plan and where completed, their review.
- We saw daily logs of people's care which were written using respectful language. Staff recorded people's well-being as well as the personal care task. For example, one record stated, '[person] was in bed when I arrived, I called and greeted [person] they smiled and said they were happy to see me'.
- People told us they were able to phone the service to request changes or to raise concerns.

Respecting and promoting people's privacy, dignity and independence
- The provider kept people's personal information secure.
- A member of staff told us about a visit they had undertaken where they had supported and encouraged a person's independent skills. The person had asked for scrambled eggs for breakfast, but the carer reminded the person that their cooker was not working. The person said how easy it was to do them in the microwave. The carer asked the person to show them how it was done. The carer had enabled the person to maintain an independent skill.
- A carer told us how happy they were to have assisted a person to wash their hair, as it made the person feel much better and happy.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

End of life care and support

- People being supported at the end of their life did not have an end of life care plan in place.
- One person who was receiving palliative and subsequently end of life care had a care plan dated February 2018. This had not been reviewed or updated when their needs changed or when they required palliative or end of life care.
- There was a Westminster Home Care policy document in the person's file entitled The Five Priorities for the Care of Dying People. It stated, '…Care is tailored to the individual and delivered with compassion - with an individual care plan in place'.
- Care plans which had been recently reviewed included a brief section where the person's future wishes had been documented.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People experienced missed calls, which meant they did not have their needs met at these times. People were supported by one carer where they were assessed to need two for safety and comfort.
- Care plans had not been reviewed within the provider's timescale. Care plans had not been updated when people's needs had changed. Care plans lacked information about what the person was able to manage independently.

Whilst there was no evidence people were harmed, these areas constitute a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The newly appointed quality officer had begun the process to review all care plans. These care plans were thorough, person centred and described how the person liked to be supported.

They contained information about the person's life history, the person's likes and dislikes, which interests they had, and their family relationships were all recorded. This meant staff supporting them knew a little about the person's background from which they could build conversations and engagement.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The provider had documentation available in a larger print when required for people with a sight impairment.

● A staff member told us how she used a wipe board and pen to communicate with a person with a hearing impairment

Improving care quality in response to complaints or concerns

● Many concerns had been raised by staff in relation to people's visits and people's care. Staff told us these had not been resolved effectively. Some staff told us communication with senior management was inconsistent which meant at times there was a lack of support.

● Concerns had been raised by people and relatives, which we were told had not been resolved in a timely manner. Two people told us they had not received telephone contact from the operations manager following a concern they had raised and were told they would be contacted the following day.

● There was a complaints file at the service and a complaints policy. According to the log one complaint had been raised and responded to.

We recommend the service records all concerns robustly and the management team respond to these in a timely manner which results in a satisfactory outcome.

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 Good. At this inspection this key question has now deteriorated to requires improvement. 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

- Quality assurance systems were ineffective. People were placed at risk and regulatory requirements had not always been followed.
- Commissioners from the local authority also expressed their concerns about people not receiving their assessed time for visits, had missed calls and people being supported by one carer rather than two.
- There had been changes to the structure of the staff team which had not been effective. There was no deputy manager. The senior carer had been assigned the office-based role of quality officer. However, they were also undertaking care visits in the morning and in the evening.
- The on-call service was not monitored effectively, many calls to the on-call service had not been logged which had resulted in poor communication. This had been highlighted in the services internal audit dated October 2019 but had not been actioned.
- One staff member told us they had worked for two weeks without a day off and others were covering many extra visits. One person told us they were concerned about one of their regular carers who had been working extremely long daily hours to cover visits. This meant staff were tired and may mean there was a higher risk of mistakes or care undertaken ineffectively.
- Audits of MARs were out of date by 4 months, therefore any errors in medicines administration were not effectively monitored or managed. Some MAR's had gaps and had medicines crossed out and re-handwritten when medicines had been changed. These had not been double checked or double signed.
- Audits of daily logs and other service processes were also several months out of date. This meant the effective investigation of missed visits may not have been managed.
- Telephone quality monitoring of the service had only just started on the second day of the inspection.
- People's financial transaction records were not recorded robustly, this meant people's money may not have been managed accurately.
- Staff training, supervision and appraisal were out of date.
- Most care plans needed to be reviewed, this was a work in progress. One person did not have and end of life care plan in place when they were receiving palliative/end of life care.
- The registration certificate of a previous manager, who de-registered in September 2018, was visible at the public entrance of the service, on the office wall. This meant people visiting the office could receive inaccurate information about the management of the service. When this was discussed with the operations manager at the time of the inspection, it was removed.

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

● Westminster Home Care (Cheltenham) lacked consistent and strong leadership. This had impacted on the culture of the service which was not positive. Most of the staff we spoke with were stressed and felt under-valued by the provider.

● The service had a registered manager however, they had been absent from their post and the service for several months.

● There had been a deputy manager and a service manager who had left after a very short time. Registered managers from other locations and the operations manager were present for short periods but staff told us this was not sufficient.

● Staff told us they did not know who they could raise their concerns with above senior management level.

● Staff we spoke with told us passionately they would go above and beyond to support the people they cared for. However, they also told us they did not have reliable and consistent leadership they required to effectively do their roles.

● We were told by the operations manager and director, a new manager had been recruited.

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

● The provider used annual feedback surveys to gain the opinions and views of people and staff. However, the providers service user forums had not taken place.

● Formal team meetings and recordings had not taken place. The most recent team meeting in November had not been recorded.

These areas constitute a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014

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

● We saw records where when things had gone wrong, the care coordinator had discussed the incident with the relevant people. We saw two other similar records where the registered manager and another locality manager had followed the concerns and complaints process.

Continuous learning and improving care

● The provider was making changes to the care planning and electronic recording systems.

Working in partnership with others

● The service was due to have a meeting with the local authority commissioners.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care End of life care plans were not in place where staff had been supporting people with palliative and end of life care. People had experienced missed visits and missed medicines administration. Care plans and risk assessments had not been reviewed. Care plans did not include information of tasks people were able to manage independently.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Notifications required by law had not been sent to the CQC. Vulnerable people had experienced missed visits, people had not received their full allocation of time for their visits. Risk assessments had not been reviewed. Moving and handling tasks were undertaken by one carer instead of two putting people and carers at risk of injury. Staff had not received a spot check of their practice. People had not received medicines when their visit was missed. There were unexplained gaps in MAR charts which were not audited. There were no PRN protocols in place or body maps for accurate application of prescribed creams. Accidents and incidents were not being effectively or accurately recorded.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good

	governance Lack of leadership and presence of Manager. High turn over of management staff. Ineffective quality assurance systems. Audits were several months out of date. The on call system was not effectively managed or recorded. Staff training, supervision and appraisal were out of date. Staff were working very long days and weekly hours. Out of date care plans and risk assessments. End of life care plans missing. Service user forums had not taken place and staff team meetings had not been recorded.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received up to date training or refreshers. Staff had not received regular supervision or appraisal. Staff were working very long daily hours and weekly hours. Agency staff were inexperienced in meeting people's needs.