Care Quality Commission

London Care Limited

London Care (Westminster)

Inspection report

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30 June 2022
05 July 2022
08 July 2022
26 July 2022
15 August 2022

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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
London Care Westminster is a domiciliary care agency which provides personal care to people living in their own homes. At the time of our inspection there were approximately 220 people using the service. 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.

People's experience of using this service
People told us they were happy with the care and support they received, although on occasions staff arrived "a little late". This feedback reflected our findings which showed staff were frequently not provided with the travel time between visits that they needed.

People's needs were assessed and planned for. However, we found some people were placed at risk by the provider when they did not receive care from two staff members together, as the provider was not following the person's agreed care plan.

People told us they felt safe and comfortable with their care workers. People were supported by safely recruited staff who received appropriate training to carry out their duties.

People felt assured that staff understood how to meet their personal care needs and support them to take their medicines, if this was part of their care plan. People commented on how staff worked in a hygienic way and took suitable action to protect them from the risk of infection.

People and their representatives were asked for their views about the quality of their care and support and they had developed positive relationships with their care workers and the office based staff team.

People were communicated with and consulted in a variety of ways including surveys, telephone monitoring calls and 'spot check' visits from supervisors and managers.

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 6 July 2021).

Why we inspected
The inspection was prompted in part due to concerns received about people's safety and the management of the service. We received information of concern in relation to whether people received scheduled visits from care staff in line with their agreed care plans, and whether some members of the care staff team had completed their annual mandatory refresher training to enable them to provide safe care and support. A

decision was made for us to inspect and examine those risks. We undertook a focused inspection to review the key questions of safe and well-led only.

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

The ratings from the previous comprehensive inspection for those Key Questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

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

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service well-led? The service was well-led. Details are in our well-led findings below.	**Requires Improvement**

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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 Health and Social Care Act 2008.

Inspection team
The inspection was conducted by two inspectors and one Expert 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 houses and flats and specialist housing.

Registered Manager
The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.
At the time of our inspection there was not a registered manager in post and the provider had commenced recruitment for a new manager.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
We reviewed information we held about the service, including the last inspection report and notifications of serious events the provider is required to inform us of. We spoke with representatives from the home care commissioning, home care contracts monitoring and safeguarding teams at the local authority. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements

they plan to make. We used all this information to plan our inspection.

During the inspection
Inspection activity commenced remotely on 30 June 2022 when we requested a range of information to be sent to us electronically, which included policies and procedures for safeguarding adults and supporting people with their medicines, infection prevention and control documents and electronic call monitoring (ECM) data. We carried out a site visit to the office location on 5 July 2022 where we spoke with two care workers, a care coordinator, the care manager, the regional director and the regional head of quality and governance. We looked at eight care plans and quality monitoring documents such as 'spot check visits' records. We looked at five staff files to check recruitment, training, supervision and appraisal.

Following the visit to the office location, we continued to seek clarification from the provider to validate evidence we found. We spoke by telephone on 8 July 2022 to six people who used the service and two relatives for their views about the quality of the service. We held a remotely conducted feedback session with the provider on 26 July 2022. We requested the contact details for further members of the care staff team and relatives of people who used the service in order to widen the scope of information we had already gathered. We concluded our telephone calls to an additional four staff members and three relatives on 15 August 2022. We spoke again with the manager of the local authority home care commissioning team.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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.

Staffing and recruitment
●People did not consistently receive their agreed level of care and support in accordance with their individual care plans. Records we checked demonstrated clear discrepancies in relation to several care visits for people who were assessed to require the support of two staff working together to ensure the safe delivery of personal care.
●For example, records showed one specific occasion when a person scheduled to receive care and support from two care staff was visited by only one staff member. The allocated second staff member was noted to be at another person's home at the same time. We found other data that showed people did not receive visits from two care workers as required by their care plan. This placed the first person at risk of harm due to inappropriate and unsafe care and support that conflicted with their assessed moving and positioning needs.
●Records also showed that care staff were not always provided with sufficient time to travel between people's homes. Our analysis of the electronic call monitoring (ECM) for April 2022 showed that 21% of calls during this month did not have any designated travel time. For example, we found that one care worker did not have travel time for 108 out of 266 visits and a second care worker did not have travel time for 115 out of 287 visits. However, records verified that both care workers arrived at people's homes with no evidence of unusual lateness or calls being cut short.
●The evidence we acquired did not assure us that people always received a safe service in line with their identified needs. For example, we noted on a specific day in April 2022 a care worker logged out of a person's home 2.44 kilometres away from the known address. The care worker was required to travel a distance of 1.1 kilometres between the homes of two people who used the agency but records showed this journey was made instantaneously.
●People and their relatives did not report distinctive concerns about the punctuality and reliability of their care staff, although there were some remarks about staff being late from time to time. Comments included, "They stay as long as they are needed and they are not late and we have never had any missed visits" and "They are a little late sometimes but they usually tell me by phone." A relative of a person who required support from two care workers together told us, "Sometimes they are a little late but the office usually let us know. It is usually when there is a double up so of course we have to wait then as they cannot start without each other."

Although we found no evidence people had been harmed, the provision of insufficient staff to safely meet people's needs and the absence of sufficient time for staff to travel between home visits placed people at risk of discomfort, harm and neglect. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Appropriate processes were in place to ensure staff with appropriate experience and backgrounds were appointed to meet people's needs. Recruitment records demonstrated the provider obtained a minimum of two suitable references which were authenticated, proof of identity and right to work in the UK and a Disclosure and Barring Service (DBS) check. DBS checks provide information including details about convictions and cautions held on the Police National Computer. This information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse
●Structures were established to protect people from the risk of abuse and harm. Staff undertook safeguarding training and explained to us how they identified different types of abuse. Staff confirmed they would telephone their line manager if they had any safeguarding concerns and felt assured these concerns would be taken seriously.
●People and their relatives told us they felt safe with their care workers because they were kind and promoted safe practices. One person told us, "Yes, I feel absolutely safe with my carers. I live alone and they make me feel secure" and a relative stated, "[Family member] has been having them for a long time and they have made her so safe. She used to have lots of falls but doesn't now. They always make sure she uses a walking frame."
●The management team at the service understood their responsibilities to protect people from abuse and harm and they reported any safeguarding concerns to the local authority in a timely way. Staff were provided with information about how to whistle blow, which is when an employee discloses information about wrongdoing in the workplace. Some care staff told us they had spoken directly with their line managers about not having enough travel time between visits to people's homes and improvements were made to their rotas.

Assessing risk, safety monitoring and management
●Clear systems were in place to identify risks to people's safety and implement measures to minimise these risks. Care and support plans' included risk assessments and accompanying risk management guidance to support staff to provide safer care. For example, there was guidance to support people at risk of falls, skin problems due to immobility and incontinence, malnutrition, dehydration and potential problems due healthcare conditions such as diabetes. We noted staff had received guidance about supporting people to stay safe and hydrated during summer heatwave conditions.
●The provider ensured there were up to date assessments in relation to people's moving and positioning needs. Where applicable the provider kept records to confirm hoists and other mobility aids used by staff to support people were subject to current checks and maintenance by the equipment suppliers. However, we could not be assured that effective checks were being carried out by the management team to ensure people who needed the support of two care staff working together for tasks such as transferring people from their bed to their chair always received this essential level of care.
●Risk assessments were carried out to identify and address any environmental risks within people's homes. For example, cluttered areas where people and staff could trip over obstacles or electrical appliances that looked unsafe.

Using medicines safely
●People received safe support from care staff to take their prescribed medicines. Care workers received medicine training and were observed supporting people with medicines by their line manager, to ensure their competency. Care and support plans provided clear information for care staff about their responsibilities in line with people's individual assessed needs, for example whether a person required prompting or a more in-depth level of assistance to take their medicine.
●People told us they were pleased with the support they received from their care staff to meet their

medicine needs, where this formed part of their agreed care and support plan. One person told us, "They deal with my medicines for me and every two weeks they collect my medication for me, there is no problem. They have been doing it for a long time now and they make sure that I take the proper tablets at the correct time."
●Systems were in place for the auditing of medicine administration records (MARs). The office management team checked MARs to ensure people received their medicines support in accordance with the provider's medicine policy and procedures and the instructions from the prescriber. Staff told us they contacted the office if they had any queries or concerns about supporting a person with their medicine and their line managers provided a helpful response.

Preventing and controlling infection
●People were protected from the risk of infection as staff followed infection control practices. Care workers received training on infection prevention and control and confirmed they were provided with the personal protective equipment (PPE) they needed, including disposable masks, aprons and gloves. A care worker informed us that the provider considered individual PPE requirements for employees such as alternative options for staff with any allergies that meant they could not use the standard stock of gloves.
●People told us they felt protected from the risk of infection when receiving their personal care as their care workers performed their duties in a hygienic and responsible way. A person using the service said, "They help me with my meal and always wash hands first and they wear the PPE" and a relative commented, "They all wear the correct PPE, if they didn't I wouldn't let them in."
●Staff carried out COVID-19 testing on themselves to protect people who used the service, in line with the stipulated government guidance for lateral flow device tests for social care workers at the time of the inspection.

Learning lessons when things go wrong
●Systems were in place to enable the service to identify and learn from when things went wrong, although this practice did not always operate effectively in relation to managing concerns due to ECM scheduling. We noted that the provider took action when they found concerning discrepancies on the ECM data, which included meetings with the staff involved to discuss the findings.
● However, we noted issues which were not thoroughly addressed to facilitate effective learning and enable the provider to gain a more comprehensive understanding of the different circumstances in which false logging in and out took place. For example, the provider had not fully investigated and established the significance of a care worker logging in at a precise distance away from the location they should have been at. We identified this inconsistency during our analysis of ECM data.
●The provider documented and analysed accidents and incidents in order to determine how issues of concern arose and what actions were crucial to prevent repetition. This learning was shared with staff at team meetings and necessary measures were implemented, for example staff training or changes to practice.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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
●The position of registered manager was vacant at the time of the inspection, as the previous manager had left the organisation. The regional manager informed us the process of recruiting a registered manager had commenced, and she was currently spending additional time at the service to support the office management and supervisory team.
●Systems to monitor aspects of the quality of the service were not sufficiently robust as we found many examples of care staff having insufficient time to travel between calls. The provider had systems in place to identify scheduling concerns, however the actions taken to respond to these concerns failed to satisfactorily address the fundamental problem of care staff not being given enough time to travel between their visits to people's homes.
●For example, one member of the care staff team did not have travel time for 77 visits out of the 332 visits that we checked on as part of our analysis of ECM data. Records demonstrated that when a care staff member asked their line manager for advice on how to manage their visits without travel time, they were informed they could not presently be advised or supported as there were not enough care staff available.
●We found evidence of a concerning practice where care staff logged in or out of visits although they were not in the geographic area. We were not able to determine where these log ins and outs were made from, although they sometimes corresponded with the distance of the previous or next scheduled visit. The provider was identifying incidences when care staff appeared to be logged in to two locations simultaneously and was implementing a system to detect when log in and log out times were incorrect.

Although the provider demonstrated it was taking actions to identify and address scheduling concerns, the provider had failed to manage the principal and core problem of care staff having impossible and unmanageable rotas .This resulted in the misuse of the ECM system and compromised the safe delivery of care and support for people. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The provider sought people's views about receiving care and support and checked that their care package was delivered in line with their identified needs and wishes. The quality monitoring and assurance processes included an annual client satisfaction survey. The results for the 2022 survey showed that 80.18% of respondents regarded themselves as being 'very satisfied' which was the highest available descriptor for customer satisfaction and a further 16.30% deemed themselves to be 'satisfied'.
●Regular 'spot check' visits were carried out at people's homes to ascertain if staff provided safe and effective care and support that met people's assessed needs and their expectations. People also received

telephone calls from the office team to check they were satisfied with their care and support. We noted the provider carried out additional quality monitoring visits and calls where they noted people's safety and wellbeing may have been impacted on by the inappropriate scheduling of visits.

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

●The provider notified the Care Quality Commission of significant events, in line with the law. They were aware of the importance of operating in an open and honest manner, in accordance with their duty of candour.

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

●People and their chosen representatives spoke positively about their experience of using the service. A person commented, "I have been having them for two or three years now…management do ring me to see how I am and how things are. They are all polite and easy to talk to in the office…and they all treat me respectfully." A relative told us, "Yes, we know who the management are…they are very easy to talk to. Nothing at the moment needs to be improved…I would recommend them."

●Care workers shared mixed views about how they were supported by their line managers to carry out their roles and responsibilities. We received some comments about rotas not providing sufficient time for travelling between people's homes although other staff stated this was not a problem they had encountered. One care worker implied they had developed their own strategies for managing their lack of travelling time, for example starting visits slightly later and finishing slightly earlier.

●Prior to the inspection we had received information of concern which alleged that some care workers had not undertaken their annual refresher training, which covered necessary topics to protect people who used the service and ensure staff maintained their own safety while carrying out their duties. For example, moving and handling, safeguarding, infection prevention and control and health and safety.

●The care workers we spoke with confirmed they had undertaken this training and appropriate evidence of current mandatory training was contained in the randomly selected staff files we looked at during the inspection. The staff training matrix showed that the provider was offering this training to staff and highlighting any gaps in completion, for example if staff were on long-term leave from employment.

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

●Staff received equality and diversity training and were provided with guidance and training to understand with empathy a range of health care conditions that impacted on the daily lives of people who used the service, such as people living with dementia or diabetes.

●The provider supported care workers and the office team to acquire knowledge about people's unique circumstances, backgrounds, interests and life histories. The service recognised and marked occasions that were important to the people they supported and the staff team, for example Black History Month, LGBT+ Pride celebrations, Eid and Christmas. This assured people that staff were trained to provide care and support in a non-judgemental manner that embraced individuality and respected people's human rights.

●Where staff had received compliments about their conduct from people who used the service, their relatives or local health and social care professionals, this was formally passed on to the individual staff members to confirm the provider recognised and appreciated their hard work and commitment.

●People and their relatives told us that their care workers respected their individual wishes about how their care and support should be delivered. For example, one person told us they always received their personal care from care workers of their own gender and another person stated they had advised the service they were happy to be supported by male or female staff. Both people confirmed the provider always adhered to

their expressed preferences.

Continuous learning and improving care
●The provider carried out a range of checks and audits to ensure care was being provided in accordance with policies and procedures. This included audits of care and support plans, daily records written by care staff and completed medicine administration records (MARS). Where necessary, care workers were asked to attend additional one to one supervision meetings with their line managers to discuss any areas for improvement identified during these checks and determine whether refresher training or other support was needed to develop their knowledge and practice.

Working in partnership with others
●The provider actively worked with relevant organisations and local professionals. The local authority carried out a monitoring visit in June 2022 shortly before our inspection and confirmed to us they found similar concerns in relation to the ECM scheduling, including staff not being given travel time and people appearing to have received visits from one care worker when their assessed safety and clinical needs stipulated they required two care staff working together.
●The provider appropriately worked with a variety of professionals and organisations in the community. For example, staff liaised with dispensing pharmacies in order to collect people's medicines and where applicable they reported environmental or other concerns to housing scheme managers and wardens. The provider sent us detailed notifications where they had contacted people's social workers to report specific concerns, for example if people did not have access to their finances for essential groceries shopping. These matters were diligently followed up until the provider was assured of people's safety and welfare and in certain situations the management team authorised for care workers to purchase basic food supplies from the office petty cash.
●The provider also operated a day service for people with dementia, which was located within the same building as the domiciliary care agency. This day centre was not in the scope of CQC regulation. This arrangement enabled the management and office team to develop beneficial links with key local professionals such as community nurses, NHS dementia care specialists and GPs.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not always assess the risks to the health and safety of service users of receiving care or do all that was reasonably practical to mitigate any such risks 12(2)(a)(b)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not operated effectively to monitor and improve the quality and safety of the services provided in the carrying on the regulated activity or maintain an accurate, complete and contemporaneous record in respect of each service user 17(2)(a)(b)(c)

The enforcement action we took:

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