

Westminster Homecare Limited

Westminster Homecare - Sheffield

Inspection report

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Date of inspection visit:
29 March 2017
03 April 2017

Date of publication:
30 August 2017

Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Inadequate 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

This inspection took place on 29 March and 3 April 2017 and was announced.

At the last inspection on 10, 11 and 17 August 2016 we found breaches in four regulations of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014: Regulation 9, Person-centred care, Regulation 12, Safe care and treatment, Regulation 13, Safeguarding service users from abuse and improper treatment and Regulation 17, Good governance. Following that inspection, the registered provider wrote to us to say what they would do to meet the legal requirements in relation to these breaches. This inspection was undertaken to check that they had followed their plan and to confirm that they now met all of the legal requirements. At this inspection we found sufficient improvements had not been made to meet those legal requirements. We found continued breaches in Regulations 9, 12, 13, and 17. We also found an additional breach in Regulation 16, Receiving and acting on complaints. This showed the registered provider had not monitored progress against plans to improve the quality and safety of the service, and had not taken appropriate action without delay where progress was not achieved as expected.

There was a manager registered with the Care Quality Commission for the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found there were not appropriate arrangements in place to manage medicines to ensure people were protected from the risks associated with medicines. The registered provider was in the process of providing medication refresher training and medication supervision to all their staff. This had been at the request of the local authority due to the nature and number of concerns they had received involving medicines.

At this inspection we found the systems in place to manage and support people with their monies were not robust and did not safeguard people from financial abuse.

We were not confident that the systems and process in place to prevent abuse of people using the service were being operated effectively at the service.

We received mixed views from people about the quality of care they had received; some people were fully, partially or not satisfied at all with the quality of care they had received.

People were supported with their health and dietary needs, where this was part of their plan of care.

At this inspection we saw some people's care plans had not been regularly reviewed or responsively when their needs had changed. We found the registered provider had still not ensured that all the people who

used the service received person centred care that was appropriate, met their needs and reflected their personal preferences, whatever they might be.

At this inspection we found the scheduling and delivery of care calls required improvement to enable all people who used the service to experience continuity of care. We found the registered provider had not taken appropriate action without delay where progress was not achieved as expected.

We found the registered provider did not have robust processes in place to enable them to respond to people and/or their representative's concerns, investigate them and take robust action to address their concerns.

We found the registered provider had failed to ensure there was an accurate, complete and contemporaneous record in respect of each person who used the service.

We found sufficient improvement had not been made to ensure there were robust systems and processes in place to assess, monitor and improve the quality and safety of the services provided.

Staff we spoke with made positive comments about the induction training they had received when they started working at the service.

We saw the systems in place to address concerns with individual staff performance required improvement.

There were recruitment processes in place. One staff member's recruitment records showed the registered manager had not adhered to the registered provider's policy and procedures. We shared this information with the director of operations.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Full information about CQC's regulatory response to any concerns found during inspections is added to

reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate ●

The service was not safe.

The service did not have appropriate arrangements in place to manage medicines to ensure people were protected from the risks associated with medicines.

The registered provider had not ensured that risk assessments relating to the health, safety and welfare of people who used the service were reviewed regularly.

We were not confident that the systems and processes in place to prevent abuse of people who used the service were being operated effectively.

Is the service effective?

Requires Improvement ●

The service was not always effective

We received mixed views from people about the quality of care they received; some people were fully, partially or not satisfied at all with the quality of care they had received.

The scheduling and delivery of care calls required improvement to enable all people using the service to experience continuity of care.

We saw the systems in place to address concerns with individual staff performance required improvement.

Is the service caring?

Requires Improvement ●

The service was not always caring.

Some people we spoke with made negative comments about some of the staff supporting them. A few people felt staff did not always listen to them.

Some people we spoke with made positive comments about the staff and told us they were treated with dignity and respect.

Is the service responsive?

Inadequate 

The service was not responsive.

People's care plans had not been regularly reviewed or responsively when their needs had changed.

The registered provider did not have a robust process in place to enable them to respond to people and/or their representative's concerns, investigate them and had taken action to address their concerns.

Is the service well-led?

Inadequate 

The service was not well led

The registered provider had not monitored progress against plans to improve the quality and safety of the service, and had not taken appropriate action without delay where progress was not achieved as expected.

We found examples of staff including the registered manager not working according to Westminster's Homecare policies and procedures.

The registered provider had failed to ensure there was an accurate, complete and contemporaneous record in respect of each person who used the service.

Westminster Homecare - Sheffield

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 29 March and 3 April 2017 and was announced. The registered provider was given a short notice because the location provides a domiciliary care service and we wanted to ensure the registered manager was available. The membership of the inspection team was two adult social care inspectors, a medicines inspector and three 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.

Before our inspection we reviewed the information we held about the service and the registered provider. For example, notifications of safeguarding and incidents. Notifications are changes, events or incidents the registered provider is legally obliged to send us within required timescales. This helped to inform us what areas we would focus on as part of our inspection. We gathered information from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used a number of different methods to help us understand the experiences of people who used the service. We contacted 31 people by telephone and were able to speak with 20 of them and six relatives. Some people chose not to speak with us and two people told us they were no longer using the service. During the inspection we spoke with the director of operations, an operations support manager, the registered manager, two quality assurance officers and the trainer. We also spoke with 12 care staff by telephone. We reviewed a range of records including the following: six people's care records, 19 people's Medication Administration Records (MARs), three staff recruitment files, three staff training and supervision files and records relating to complaints, care rotas and the management of the service.

Is the service safe?

Our findings

At the last inspection in August 2016 we found concerns relating to the care people had received. This was a breach of Regulation 12, Safe care and treatment of The Health and Social Care Act 2008 (Regulated Activities) 2014. The registered provider sent us an action plan detailing how they were going to make improvements. During this inspection, we checked to see what improvements had been made.

At the last inspection we found people's risk assessments were not being regularly reviewed to ensure they reflected people's changing needs. The purpose of a risk assessment is to put measures in place to reduce the risks to the person so it is important these are completed regularly so they balance the needs and safety of people using the service with their rights and preferences. At this inspection we found some people's risk assessments were still not being regularly reviewed or in response to a person's change in their needs. For example, we looked at two people's care plans; we saw that a new risk assessment had not been completed when their needs had changed. We looked at the risk assessments reviews that were due in February 2017, we saw twenty people's risk assessment reviews had not been completed and were overdue. This showed the registered provider had not ensured people's risk assessments were reviewed regularly or responsively when there was a change in needs.

At the last inspection we found concerns relating to the management of medicines. During this inspection, we checked to see what improvements had been made. We looked at a total of 19 Medicines Administration Records (MARs) and spoke with the registered manager, operations support manager, quality assurance assistant and one member of staff responsible for medicines. A few people we spoke with told us they had experienced concerns with the management of their medicines. For example, one person told us they had not received their medication on two occasions and had reported this to the office.

The level of support that individual people needed was recorded in their care plan. We reviewed MARs and found gaps in ten out of 19 records where staff had not signed or entered the reasons for not administering medicines. For example, on one person's MARs we found staff had failed to sign to confirm they had administered all medicines prescribed on three days between 07 and 28 January 2017. This meant MARs did not accurately reflect the medicines people had received.

We found medicines were not always given as prescribed. For example, one person was prescribed a long acting pain killer to be given 12 hours apart. On four occasions between 18 and 30 October 2016 staff did not administer the next dose and the recommended 12 hours had elapsed. This meant that staff were not giving medicines in a way which met with the individual needs of the person and there was a risk of the person suffering from pain.

One person's MAR had been handwritten; we found the specific dosage instructions to apply eye drops in both eyes had been incorrectly transcribed. The new MAR did not say which eye(s) should be treated. A second check had not been carried out by the staff to confirm dosage instructions had been transcribed accurately.

Some people were prescribed a medicine used for blood thinning. During the inspection we found examples where staff had failed to sign to confirm they had administered the medicine. One person had not received any doses of their medicine(s) on six days in December 2016 and four days in January 2017. We spoke with the registered manager who was unaware of the problem and could not give us an explanation.

One person was prescribed a medicine for pain to be taken regularly four times a day. This was documented on the list of currently prescribed medicines in the person's care plan. However, the medicine was not listed on the MAR and the person had not been given this medicine. Therefore, this person was not receiving the treatment as it had been prescribed and there was a risk of them suffering from pain as a result. In addition, staff had not undertaken an assessment of the person's level of pain.

Some medicines were prescribed to be given as and when people required them, known as 'when required' or 'PRN'. We found no evidence of protocols in place as documented in the organisation's medication policy and procedure to guide care staff when and how to administer these medicines safely. There was no guidance available to support staff to give people their medicines according to individual preferences.

We saw the guidance for medicines which should be given at specific times had not been written on some people's MARs. For example, one person was prescribed a medicine which should be taken 30 minutes before breakfast when the stomach is empty, but this was not written on their MAR. Another person was prescribed a medicine which should be taken whilst upright and 30 minutes before eating or drinking, but this was not written on their MAR. Not administering medicines as directed by the prescriber increases the risk of the person experiencing adverse effects from the medicine, or the medicine not working as intended.

We saw the use of patch charts and body maps for people who needed a pain relief patch. This meant it was clear to staff where and when patches had been applied, and reduced the risk of harm from duplicate application. Some people were prescribed external preparations, like creams and ointments. We found there was lack of written guidance in place to explain to staff where or how much to apply.

During the inspection we were given a list of people who required time critical calls. We found a few people did not have time critical calls scheduled on the rota. For example, one person who needed to take their medicines at right time each day was not on the list as being time critical. Therefore, we could not be sure that this person had received the medicines they needed at the correct time.

These was a continued breach of Regulation 12 Health and Social Care Act (Regulated Activities) Regulations 2014, Safe care and treatment.

At the last inspection we found there were not robust systems in place to safeguard people from the risk of financial abuse and we found the registered provider in breach of Regulation 13. The registered provider sent us an action plan detailing how they were going to make improvements. At this inspection we found that sufficient improvements had not been made to ensure people were safeguarded from financial abuse. For example, we looked at three people's financial transaction records. We found anomalies in two people's records, but there was no evidence to show these anomalies had been investigated or an explanation obtained.

We were also not confident that the systems and process in place to prevent abuse of people who used the service were being operated effectively. For example, that untoward incidents were being reported appropriately by office based staff. We reviewed the service's safeguarding file, but we were unable to establish how many allegations had been made, the nature of the allegation, the outcome and the action taken. We spoke with the registered manager and they were not able to provide us with this information.

We shared this information with the director of operations. After the inspection the local authority provided us with details of the ongoing investigations.

This was a continued breach of Regulation 13, and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safeguarding service users from abuse and improper treatment.

At this inspection we received mixed views regarding the service's staffing levels. The feedback received from people who were supported by regular staff and experienced regular call times was positive. However, those people who were not supported by regular staff and/or did not experience regular call times raised concerns about the quality of care they had experienced.

The service was using agency staff to ensure people received their care calls and there was rolling programme in place to actively recruit new care staff. Some of the people and relatives we spoke with expressed concerns about the quality of care provided by some of the agency staff. This showed there was a risk that people were supported by staff who did not have the competency, skills and experience to do so safely. The director of operations told us the registered provider was actively recruiting new care staff for the service. The registered provider's actions to reduce the amount of agency staff was being monitored by the local authority on a regular basis. The director of operations showed us evidence that the level of agency staff being used by the service was being reduced.

People we spoke with did not express any concerns regarding their safety. People's comments included: "Yes I do (feel safe). Luckily they [staff] wear name badges as you never know who is supposed to be coming" and "I feel safe with the carers, they knock on the door, they do wear name badges and sometimes if they are from the agency or new they tell me who they are. I never know who is coming when the regular carer is off."

Care staff we spoke with were knowledgeable about their roles and responsibilities in keeping people safe from harm.

We reviewed staff recruitment records for three staff members. The records contained a range of information including the following: application, references, employment contract and Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service (DBS) provides criminal records checking and barring functions to help employers make safer recruitment decisions. One staff member's recruitment records showed the registered manager had not adhered to the registered provider's policy and procedures. We shared this information with the director of operations so that appropriate action could be taken.

We received mixed views from people we spoke with regarding infection control. Some people did not express any concerns and told us that staff used gloves and aprons appropriately. A few people told us that some staff did not use the aprons because they were not big enough.

Is the service effective?

Our findings

At the last inspection in August 2016 we found a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) 2014, Person centred care. The registered provider sent us an action plan detailing how they were going to make improvements. At this inspection we checked to see if improvements had been made. We found sufficient improvements had not been made.

We received mixed views from people about the quality of care they had received; some people were fully, partially or not satisfied at all with the quality of care they had received. People were supported with their dietary needs, where this was part of their plan of care

The feedback we received from some people who used the service, staff and care rostering records told us the scheduling and delivery of care calls still required improvement to enable people to experience continuity of care. We found some of the actions the registered provider told us they would do had not been completed. For example, the registered provider had not ensured that all the people who required time critical calls were recorded in the provider's electronic rostering system. The registered provider told us they would take action to improve the rostering of calls to enable people to be supported by regular care staff and experience regular call times. We saw the service had not successfully completed their implementation plan to reduce the percentage of unscheduled hours. The aim of the implementation plan was to ensure that people would experience good continuity of care and meet people's needs, welfare and safety. The target for Westminster Homecare was less than 10% of the total weekly hours. The director of operations told us the percentage of unscheduled hours for the service was 30%. This showed the registered provider had not monitored progress against plans to improve the quality and safety of the service, and had not taken appropriate action without delay where progress was not achieved as expected.

We found the registered provider had still not ensured that all the people who used the service received person centre care that was appropriate, met their needs and reflected their personal preferences, whatever they might be.

This was continued breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person- centred care.

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. We checked whether the service was working within the principles of the MCA.

During the inspection some of the people we spoke with told us they were supported to be as independent as possible. At the last inspection we saw that people had not been asked to sign their care plan to show they were actively involved in the assessment and had consented to the care plan. At this inspection we saw that this was still the case and still required improvement.

The registered provider used a training software package to monitor the training completed by staff. Staff were assigned dates for when they needed to complete their training. We saw there was a robust system in place to ensure staff received regular refresher training. However, our findings during the inspection showed the checks completed on their competency to administer medicines safely required improvement. The registered provider was in the process of providing medication refresher training and a medication supervision for all staff. This had been at the request of the local authority due to the nature and number of concerns they had received involving medicines.

Staff we spoke with made positive comments about the induction training they had received. Their comments included: "Induction was very good. There was a lot more to it than I expected," "I think the training offered by the company is really good. Much better than I thought it would be." and "My induction was much more thorough than I expected. I had a full week of lectures and videos with tests as well. There was a written exam which was to make sure you had really understood everything."

We received mixed views from people and relatives we spoke with in regards to staff training. Some people and relatives felt staff were well trained, whilst others told us that care staff needed more training on delivering care. For example, one person told us staff did not dry them properly and put some of their clothes on inside out. Some people we spoke with required stoma care (an artificial opening), they told us staff would benefit from receiving training from a district nurse.

Care staff we spoke with told us they felt supported. We reviewed the arrangements in place to ensure staff received regular supervision and an annual appraisal. Supervision is regular, planned and recorded sessions between a staff member and their manager to discuss their work objectives and wellbeing. An appraisal is an annual meeting a staff member has with their manager to review their performance and identify their work objectives for the next twelve months. We saw the systems in place to address concerns relating to a staff member's performance needed to be improved. For example, concerns regarding a staff member's competency to administer medicines or the handling service user monies were not being identified in a timely manner, in some cases this took several months. We also saw the objectives set in the staff member's previous supervision were not always reviewed at their next supervision. Our findings during the inspection showed the systems in place to make sure staff competence was maintained required improvement.

Is the service caring?

Our findings

At this inspection people and relatives we spoke with gave us mixed views regarding the staff working for Westminster Homecare-Sheffield.

Some people we spoke with were not supported by regular care staff and/or did not experience regular call times. They felt they were not treated in a caring and compassionate way. One person described why it was important to be supported by regular care staff. They said: "You form a rapport if you have the same faces and it's better when like me you can't get out. The people that come into your home is very important more than just care it's the social side of things". During the inspection we found a few people were not being supported appropriately with their continence care needs. For example, one person described to us the results of experiencing an early bed call and a late morning call and how this impacted on their dignity.

The feedback we received from some people and relatives about the communication they had received from the office based staff showed that people or their representative were not always treated with a caring approach. It is important that a service makes sure people feel they matter, and that staff listen to them and respond to calls for assistance appropriately. One person we spoke with shared their experience: "I don't think staff always listen to me let alone act on my views, but the office staff are worse."

Some people we spoke with made very positive comments about the staff in particular their regular staff. The positive comments made included: "[Care staff member] is very good, she's absolutely fantastic. She's more like a mother to me. She treats me like one of her children, but it's lovely," "I look forward to them [care staff] coming, my neighbours don't bother and when you're on your own it's nice to have a bit of company" and "I have absolutely no complaints with the care staff. They are very polite and we can have a laugh and a joke. They let me be as independent as I can be and they step in if I need them."

Some relatives also made positive comments about the care staff supporting their family member. One relative commented: "The carers are lovely, very good indeed. [Staff member] sings to him [family member] in the shower and [family member] loves it".

Relatives and people we spoke with told us they did not hear staff discussing any personal information openly or compromising people's confidentiality.

Care staff we spoke with gave examples of how they treated people with dignity and respect and maintained their privacy. One staff member commented: 'I always ask people what they want. It's not always easy when they've got dementia, but things like what clothes do you want to wear today? It's just good manners really.' Care staff we spoke with told us they were not introduced to people or given the opportunity to read their care plans before they started supporting them. They got to know people by regularly supporting them.

People were not provided with any information about advocacy services. These are services that are able to speak up on their behalf.

Is the service responsive?

Our findings

At the last inspection in August 2016 we found a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) 2014, Person centred care. The registered provider sent us an action plan detailing how they were going to make improvements. At this inspection we checked to see if improvements had been made. We found sufficient improvements had not been made.

At the last inspection we found that some people's care plans and risk assessment had not been regularly reviewed in response to a change in needs. The registered provider told us they would take action to ensure people received an annual review of their care plans and in a response to a change of needs. At this inspection we found some people's care plans and risk assessments had not been regularly reviewed. We also found there was not a robust system in place to ensure people's care plans were reviewed in response to a change of need. People's comments included: "Two years ago when I started needing care they did discuss my needs with me and my husband and we did get what we wanted. They [staff] now tell us how busy they are and how they have to fit other clients in which means they don't always do what I need" and "I have never seen my plan or a list of what they should or could do for me. It would be useful to know and they and I should be aware of the length of the times they are supposed to stay with me."

We looked at the records of people who had raised concerns regarding the care they had received since the last inspection. We saw the service's failure to review some people's care plans when their needs had changed had contributed to them not receiving appropriate care. We shared this feedback with the director of operations. This showed the registered provider had not monitored progress against plans to improve the quality and safety of the service, and had not taken appropriate action without delay where progress was not achieved as expected.

This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person-centred care.

Although there was a system in place to respond to complaints, we found the registered provider had not ensured the system was being operated effectively. The feedback received from some people and/or their representatives showed the handling and responding to complaints required improvement. A few people told us that they had contacted the local authority after their complaint to the service had not resulted in appropriate action being taken or the action taken was not sustained or completed. People's comments included: "I complained to the office nothing improved," "No they [service] don't seem to learn from complaints and concerns raised. Nothing has improved" and "No nothing changes no matter how many complaints you make." Some of the people and relatives we spoke with shared their experience of contacting the office staff to raise concerns. One person commented: "I don't think the office staff listen to you. When you do complain the message does not go through to the right person so I continue to get problems."

During the inspection we looked at a sample of telephone monitoring records. Staff used this form to record the feedback from people who used the service. Where concerns had been raised by the person or their

representative we saw action had not always been taken to resolve these concerns. We were not confident that office staff were responding appropriately to people or their representative when they made a verbal complaint or raised a concern.

We shared this information with the director of operations. We found the registered provider had not ensured that any complaint received was investigated and that the necessary and proportionate action had been taken and sustained in response to any failure identified by the complaint or investigation.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Receiving and acting on complaints.

Is the service well-led?

Our findings

At the last inspection in August 2016 we found a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) 2014, Good governance. The registered provider sent us an action plan detailing how they were going to make improvements. This inspection was undertaken to check that the registered provider had followed their plan and to confirm that they now met all of the legal requirements. At this inspection we found sufficient improvements had not been made to achieve compliance. We found a continued breach in Regulation 9, Person-centred care Regulation 12, Safe care and treatment, Regulation 13, Safeguarding service users from abuse and improper treatment and Regulation 17, Good governance. We also found an additional breach in Regulation 16, Receiving and acting on complaints. The showed the registered provider had not monitored progress against plans to improve the quality and safety of the service, and had not taken appropriate action without delay where progress was not achieved as expected.

Most of the people and the relatives we spoke with did not know who the registered manager was for the service. People's comments included: "I have never been asked for feedback since receiving care from this company and I have no idea who the manager is or her or his name" and "I have no idea of managers' names. I feel they need improvement in the hub [office] as this is where things go wrong."

We received concerns about the communication some people and their representatives had received from the office based staff. It is important that feedback from people and those acting on their behalf should be recorded and responded to as appropriate. People's comments included: "No they [office staff] don't tell you if they [care staff] are going to be late especially when it is agency staff. I have told the office, but messages are not getting through to the right person so I am still getting problems," "If they don't come e.g. last week it was gone 10.30am and no-one had been so I rang the office and eventually someone came. If I didn't ring I am not sure I would get my carers. Note this has happened even though three weeks ago they promised to rectify late calls," "The office is not efficient" and "The office staff do not keep in touch even when they say they will."

As part of their governance registered providers must seek and act on the feedback from people and those acting on their behalf, staff and other stakeholders. We saw the systems in place to act on the feedback received via telephone monitoring required improvement.

Our findings during the inspection showed the registered provider had failed to ensure the systems and processes in place to assess, monitor and mitigate the risk relating to the health, safety and welfare of service users were effective. We also saw the quality of some of the audits undertaken at the service required improvement. For example, an audit of people's Medication Administration Records for November 2016, were not audited by staff until March 2017. It is important that systems and processes are in place to identify where quality and safety have been compromised and to respond appropriately and without delay.

We found examples of staff including the registered manager not working according to Westminster's Homecare policies and procedures. For example, a safeguarding log had not been maintained. We were not confident that accidents and untoward occurrences were being monitored by the registered manager to

ensure any trends were identified.

We also found concerns relating to records at the service. For example, the registered provider had failed to ensure there was an accurate, complete and contemporaneous record in respect of each person who used the service.

The operations support manager told us they had not seen the local authority's home care monitoring visit report. The purpose of the local authority visit was for the service to follow up on action since their last monitoring visit. Registered providers must monitor progress against plans to improve the quality and safety of services. During the inspection the director of operations and the operations support manager both told us the registered provider was fully committed to improving the service.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users must be protected from abuse and improper treatment in accordance with this regulation. Systems and processes must be established and operated effectively to prevent abuse of service users.
Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Any complaints received must be investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation.

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 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service user must be appropriate, meet their needs, and reflect their preferences.

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users.

The enforcement action we took:

We issued a warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with regulations.

The enforcement action we took:

We issued a warning notice.