Westminster Homecare Limited

Westminster Homecare Limited (Colchester)

Inspection report

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Date of inspection visit:
12 September 2016
15 September 2016
28 September 2016

Date of publication:
14 November 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place between the 12 and 28 September 2016 and was announced.

Westminster Homecare is a domiciliary care agency, delivering services in the Colchester and Clacton area of Essex. At the time of our inspection the agency was supporting 130 people.

The service has a registered manager. 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.

Following our last inspection in September 2015, we asked the provider to take action to make improvements as we found risks to people's health, welfare and safety had not been identified and monitored and people's medicines were not being managed safely. We also identified that complaints were not responded to and managed effectively. The provider provided us with an action plan in which they set out what steps that they were going to take to ensure improvement. We rated the service Requires Improvement

We carried out this inspection to check whether the actions that they told us they had taken had led to improvements. We found at this inspection that they had provided additional training for care staff on medicine management and increased the spot checks of staff. However, whilst there were improvements in some areas, we continued to find issues with the management of medicines which meant that people continued to be at risk. We found that complaints were logged and investigated but the concerns that people raised about scheduling of their care calls and the timings of their calls were not always taken seriously. This meant that people did not have their concern acknowledged or addressed.

There were adequate numbers of staff however people expressed concerns about consistency and communication. The regional manager told us that they were working on this and there were flexibility with the timings. However travel time was not always programmed into staff schedules and this meant that the times they supported people could vary.

Risks such as those associated with the environment were identified and there were plans in place which set out how they should be managed. Care plans were in place but they were not always sufficiently detailed which combined with a changing workforce meant that people were at risk of receiving inconsistent care.

The provider had policies in place with regard to the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA) 2005. The Act, Safeguards and Codes of Practice are in place to protect the rights of adults by ensuring that if there is a need for restrictions on their freedom and liberty these are assessed and decided by appropriately trained professionals. Care staff had a good understanding of the importance of obtaining consent and protecting people's rights.

People were supported with meals and staff worked with health professionals to support people with their health care needs.

People's independence was promoted by staff and people felt involved in their care. People had good relationships with the staff and were treated with dignity and respect.

Staff told us that they were supported and trained. There were effective systems in place to respond to staff and people who used the service outside office hours.

Staff were positive about the manager who was accessible and had started to implement change.

There were systems in place to monitor the quality of care which included spot checks and audits. However these were not always comprehensive or effective at identifying and addressing the issues such as those that we identified around medication, infection control, complaints and scheduling.

During the inspection we identified continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and you can see what action we told the provider to take at the back of the full version of the report

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 consistently safe.

People's medicines continued not to be managed safely.

There were adequate numbers of staff available to support people but people did not always receive care from a consistent person at a consistent time.

There were systems in place to reduce the risk of abuse as staff had undertaken training in identifying and responding to concerns.

Risks were identified and actions put into place to minimise the risks to people.

Infection control procedures and actions taken by staff did not always work effectively to protect people from the risk of acquiring infections.

Is the service effective?

Good

The service was effective

Staff received training and support to enable them to meet the needs of people who used the service.

People were supported to make decisions about their care and staff had a good understanding of consent.

People were supported to access health care when they needed to.

Is the service caring?

Good

The service was caring

People were supported by staff that were kind and caring.

Staff were respectful of people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were systems to respond to complaints but it was not effective as some issues were not recognised as complaints.

Care plans were not always sufficiently detailed about people's needs and monitoring systems were not always responsive. This meant that people were at risk of inconsistent care.

Is the service well-led?

Requires Improvement

The service was not well led

There was a system in place to monitor the quality of the care but this was not working effectively and issues were not being picked up and addressed.

Staff were positive about the new manager and the support they received.

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Detailed findings

Background to this inspection

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

The inspection took place on the 12,15 and 28 September 2016. The inspection was announced. We gave the service 48 hours' notice that we would be doing the inspection so that they could make sure the necessary people were available at the office when we called. The inspection team consisted of two inspectors and an 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, and their expertise was in the care of older people.

Before the inspection, the manager completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also sent out fifty questionnaires to people who use service and staff about their experience of the agency. We had twenty nine responses from people who used the service and their relatives and responses from nine staff.

In advance of our inspection we reviewed the information we held on the service, in particular notifications about incidents, accidents and safeguarding information. A notification is information about important events which the service is required to send us by law. We looked at safeguarding concerns reported to us. This is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect. We also contacted the local authority quality team and we used their comments to support our planning of the inspection.

As part of the inspection, the expert by experience spoke on the telephone to fifteen people who used the

service and six relatives. We undertook visits to three people who received care in their home and spoke to staff both in person and by telephone. In total we spoke with twelve care staff as well as six staff from the head office team, including the trainer, the coordinators, the manager and regional manager

We reviewed a range of documents and records, including care records for people who used the service, records of staff employed, complaints records, medication, accident and incident records. We looked are records of staff meetings and a range of quality audits and management records.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection in September 2015 we found that medicines were not being managed safely. At this inspection we found that steps had been taken to address some of the issues through training for staff and the provision of additional guidance. However we continued to find shortfalls in how medicines were being managed. For example, medication administration records were found to be incomplete and medicines were not all itemised which could cause confusion. For example, one individual was prescribed paracetamol but it was not clear from the records how often this should be administered. There were gaps in the records and these were not being picked up until they were returned to the office for auditing which was not until the end of the month.

We audited one person's medicines and saw that the medicine administration record did not record when the medicines had been received and we found two days missing from the blister pack which we could not account for. This individual had a diagnosis of dementia and we were concerned that the risks associated with their access to medicines had not been fully assessed. We showed this to the supervisor and they were also unable to explain what had happened to the missing medication. For another person we saw that medicines were being crushed and administered through a Percutaneous endoscopic gastrostomy (PEG) which is a tube which is used to deliver nutrition and goes through the stomach wall. However there was no written guidance for staff to follow in managing this or delivering medicines in this way. Staff were not clear about what constituted actual administration as opposed to prompting an individual with their medication. We looked at the provider's medication policy and saw that the guidance provided to staff on administration did not correspond with the nationally recognised guidance.

This is a continued breach of Regulation of Regulation 12(g) Safe Care and treatment of the Health and Social Care Act 2014.

Staff were available to meet people's needs but people did not always receive support from a consistent carer at the time they preferred or told to expect. Staff told us that the agency was adequately staffed and the agency only accepted new packages of care if they had the staff available in the location to support them. Some staff told us that they had regular people they supported each week but others told us that they picked up other staff members work when they were on their days off. Staff told us that 99% of packages were allocated but changes occurred when people were ill or cover was needed for holidays.

Peoples experience varied. Most people expressed concerns about the punctuality of their visit and the fact that carers were "rushed." Some people told us that that they did not mind the call being later but almost everyone told us that they were not told beforehand. One relative told us that the agency had a habit of "swapping carers around and of "overloading them." One person told us , "You don't know if you are coming or going…I shouldn't have to call them to ask where the carers is." The manager told us that they sent out information to people on a weekly basis and tried to ring them when there was changes but people told us that there was a lack of information and, "They send out a rota each week but they many as well not bother. It is not accurate and the times are often wrong."

Staff told us that they had been interviewed and that all relevant checks had been obtained to ensure that they were suitable to work with people who used the service. We looked at recruitment files for two staff and saw that references, identification checks and criminal records checks had been undertaken prior to their starting their employment. Staff told us that the provider had a policy of verifying references

People who responded to our questionnaire raised concerns about staff members understanding and implementation of good infection control practices. We followed this up on our visits and observed that a number of staff were wearing false nails, which was not line with the organisations infection control policy. Staff were observed wearing gloves however they were observed not to change their gloves after each task. There was a lack of handwashing as staff were complacent believing the gloves offered protection which is contrary to Department of Health good practice guidance for staff in a social care setting.

Staff told us that they were provided with information about risks and there were clear arrangements in place regarding key codes and access to people's homes. We noted that people's care plans contained assessments of risk relating to the environment, including fire safety, the use of electrical and gas appliances, and equipment such as a hospital bed. Guidance was given to staff about how risks should be managed to keep people safe. Staff told us that that they had undertaken training in moving and handling and they were able to tell us the actions they had taken following accidents to ensure people's safety. We saw that these actions were recorded in people records.

People we spoke with told us that they felt safe with the care staff. We found that people were protected from the risk of abuse because staff were trained to identify and report any concerns they might have. Staff had access to guidance to help them identify abuse and respond in line with the provider's policy. Records showed that staff had received training in keeping people safe from the risk of abuse and they were able to tell us about what was covered in their training and what they would do if they had any concerns. The manager maintained a log of safeguarding incidents and details of the investigation and outcome.

Good

Is the service effective?

Our findings

Staff had the skills and knowledge to meet people's needs. One person told us , "I think that they have some training but they could do with more. Some say they have got NVQs when I ask them."

Staff told us that the induction training they received was informative and provided them with the knowledge they needed. We saw that care workers completed initial induction training which covered areas such as health and safety, nutrition, safeguarding and moving and handling. We noted competency assessments and quiz's on staff files which staff completed after training to demonstrate their understanding of what they had learnt. Staff told us that as well as the training they shadowed an experienced member of staff before working unsupervised. We saw that new staff had a twelve week development plan which set out the areas that they should cover and support they should expect. This included support telephone calls , supervision and spot visits.

A new branch trainer had been appointed to oversee the provision of training and we saw that training had recently been provided on areas such as dementia care and medication administration. All care staff had been booked onto refresher training which was held on a rolling basis of between one to two years. Attendance was monitored via a software package and staff who consistently failed to attend were taken off shift until the mandatory training was completed. Staff were positive about the quality of the training and told us if they had a query on areas such as moving and handling the trainer would come onsite and give them the guidance that they needed. One member of staff said the training was, "Much Improved..." another told us that that although they had worked in care of many years they had "Learnt something new at the training." We saw that where staff were using specialist equipment such as a PEG, they had undertaken training to make sure they could use it safely.

Staff said that they were well supported and could contact the office and the out of hours on call person at any time. Staff meetings were held regularly with the support workers in the different geographical locations. Staff told us that they received supervision from a senior member of staff to discuss how they were progressing. We saw records which evidenced that staff also received work performance spot checks when working in a person's home. This was to ensure that the quality of care being delivered was in line with best practice and reflected the person's care plan.

Care staff had an understanding of the Mental Capacity Act (MCA) and described to us how they gave people choices in the way they wanted to be cared for. We saw records which evidenced that individual's capacity had been assessed. If individuals did not have the capacity to make specific decisions around their care, the staff involved their family or other healthcare professionals to make a decision in their 'best interest' as required by the Mental Capacity Act 2005. A best interest decision considers both the interests of the person who lacks capacity, and decides which course of action will best meet their needs and to keep them safe.

People were supported at mealtimes to access food and drink although much of the food preparation at mealtimes was minimal, with family members preparing the food in advance or people having frozen meals ready to be reheated. People we spoke with were satisfied with the food served to them. People nutritional

preferences were included in their care plan for example we saw that one person liked a boiled egg cooked for 5 minutes

The majority of health care appointments were co-ordinated by people or their relatives. However we saw from the care records that staff were available to support people to access healthcare appointments if needed and liaised with health and social care professionals involved in their care if their health or support needs changed. For example we saw that office staff had contacted the GP and community matron to review an individual's care

Good

Is the service caring?

Our findings

People were complimentary about staff and told us that they were treated with kindness and consideration. They had good relationships with their carers and told us that the issues about timeliness were due to scheduling of their care calls and not the carers, who "tried their best." One person told us that they were like friends and another person told us that their carers were "Fantastic." There was only one person who said, "One of them is a bit rough and not very good at giving me a good wash." When asked if she felt she could inform the office of this she said, "I would not want to get anyone into trouble I just think she is a bit young and not very experienced."

Staff were observed to be kind, caring and considerate of people during our visits. Where one person was unable to verbally communicate sufficiently it was evident from their body language and eye movements that they felt safe and comfortable in the presence of staff. They responded with smiles and thumbs up sign when asked if staff were kind and we noted they responded positively when communicated with by staff.

The staff we spoke to had a good knowledge about people's needs and were able to tell us about people's preferences daily routines and their likes and dislikes. Some staff said that they supported the same people and knew them well. People told us that they were treated with respect and staff listened to them, often asking If there was anything else they could do before they left. Another person said, "They are all very good and kind. Some like to do things their own way and don't always listen to you but otherwise I am happy."

People told us that they were assisted to retain their skills and maintain their independence An example given was with areas such as personal care and being encouraged to wash as much as they could. One person told us that they were supported to access the community and, "I wouldn't be able to get out if it wasn't for them." Another person described how staff had worked with them on improving their mobility and continence and how this has helped them. Staff told us that they were encouraged to assist people to remain independent and allow people to do things for themselves if they wanted to. Care and support plans were written in a positive way and outlined what people could do.

People told us that staff were respectful of their privacy and maintained their dignity. One person told us that their carer had brought along another carer to shadow them but when personal care was being provided their main carer protected their dignity by shutting the bathroom door and leaving the new carer in the other room.

We saw that the provider had undertaken a survey to ascertain people's views on the service and the results were generally positive with people saying that they felt safe.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive to people's needs. At the last inspection we asked the provider to take action to investigate and take action to address all complaints received. The provider sent us an action plan, which stated that they acknowledge complaints within 48 hours and were confident that all staff who dealt with complaints were dealing with them correctly and efficiently. We looked at the policy and the records of complaints and we saw that there was a clear process which included investigation and responding to the complainant at the end of the process. However the feedback we received from people and relatives was that the scheduling and delivery of calls required improvement and people were frustrated that their concerns were not addressed. We found that these concerns about timeliness and scheduling had not been logged as complaints or concerns which meant that people did not receive a clear outcome or closure.

Around half of the people we spoke with told us that they had raised an issue or made a complaint and most of the concerns centred on the office staff not giving them adequate information about a carer being late or a change in time without them being consulted.

One person told us, " I called the office when the carer was late. At one time the office let me know but it seems that it's up to the carers to let us know. I sometimes feel that the office does not care. They have been offhand." Another person said, "They don't ring you to tell you if someone is going to be late. They just tell you what they think you want to hear." One person told us , "They always say that they will look into it and apologise but then nothing happens." One relative spoke about the lack of reliability and the impact of the late calls on their wellbeing, they said, "The stress is enormous."

Care plans did not always provide staff with sufficient detail to ensure people's would receive consistent and safe care. People told us that their preferences for areas such as meals and the gender of carers was respected by the agency. One person told us that they sometimes had a male carer come to give personal care but they ,"Didn't mind . He is discreet and always asks me if I am ok." Some staff clearly knew people well and supported the same individuals on a regular basis but those who did not found the fact that care plans were not detailed problematic. One person said, "The care plans are not what the person needs anymore."

We looked at a sample of care plans and found that they varied in the level of detail provided to guide staff, some people had pen pictures describing people's needs but not all. One person had a PEG in place but there was no clear plan in place or an assessment of the risks associated with peg feeding. Moving and handling plans were not detailed and there was no concise description of how to use the equipment to ensure safe practice. One person had a catheter but there was no clear guidance on when or how the bags should be changed which placed the individual at risk of acquiring an infection and receiving inconsistent care.

One person exhibited distressed behaviours but when we looked in the care plan it stated that staff should be reassuring and patient but there was not sufficient analysis of the root cause and indicators of their

distress and how staff should respond.

Monitoring systems for those at risk were not fully effective. Daily records were in place and records were maintained of people's dietary and nutritional intake. Where there were concerns or an individual was refusing to eat the policy was that staff should ring the office who would take the matter forward. However we saw an example where this had not occurred consistently and were not assured that the service was being as proactive as it should be. This was further complicated by changes to the care plan not always updated promptly which placed people placing people at risk of receiving poor care.

Requires Improvement

Is the service well-led?

Our findings

The provider had systems in place for auditing the quality of the care but these were not sufficiently robust. They had not fully addressed the shortfalls we found at the last inspection and monitor the quality and safety of the care to ensure that change was imbedded into practice. They also had not identified some of the shortfalls that we had found at this inspection.

We reviewed a sample of audits which were undertaken which included the daily records completed by staff and medication charts. The audit focused primarily on documentation and where shortfalls were found, reminders were sent out to staff about the importance of recording accurately. The audits were not comprehensive. For example we found the systems in place to manage and support people with their money did not provide sufficient safeguards to protect people from the risk of financial abuse. Staff completed a running record but there was no auditing of these records and the management of the service were not checking that staff were completing the transaction records correctly and accurately.

The audits did not identify or action some of the issues people raised regarding scheduling of care calls and we were concerned that some people may not receive their full allocation of time. We saw that telephone monitoring was undertaken by office staff and field care supervisors conducted home visits to ascertain people's views. While there was a significant number of positive comments, such as, "The care is very good."….. "It's a lot better than it was." There were also records which evidenced that people had raised issues such as, "I don't think they stay the full time ." We saw that one individual had responded to the question how to make things better by asking to be kept informed when staff were late.

We saw that there was a signature sheet attached to the staff work programme for people to say that they had agreed the actual time carers said they had spent providing support. Our review of these records showed that some staff had recorded that they were in two places at the same time. Some were not able to show us their work programmes as they did not carry them with them and told us that they only completed these sheets at the end of the week. This meant that people had not been provided with the opportunity to evidence the amount of time staff claimed they had spent providing care on their time sheets. The information from staff time sheets was used to invoice people or the local authority for their care and meant that people could be charged for care they did not receive. The operational manager told us that calls could be thirty minutes either side of the agreed time and that travel time was scheduled at the end of the day. Carers however were not all aware of this and one person told us that did not have travelling time and had to cut their visit to people short to make up for the time. This meant that people may not receive their full allocation of time and a lack of robust system put people at risk of miscalculations for invoicing purposes.

This is a breach of Regulation 17 Good Governance of the Health and Social Care Act 2014.

The provider's operational manager regularly visited the service and provided ongoing support to the newly registered manager. All the staff we spoke with were complementary about the new manager and the support they provided. One member of staff told us, "Things are more settled here." Another member of staff said, "Things are better, we have a manager who is supportive and knowledgeable…." The service has

changed in leaps and bounds. And people are happier.".
There was some agreement between people that the situation regarding carers being changed at the last minute had recently improved but that there was still some way to go in terms of communication. One person told us, "The two sides (cares and management) are not working together." One carer told us that one of the issues was that the office did not listen to them and when they told them that they had too much to fit in and it would mean they were going to be late they were told, You will manage it…. it is like speaking to a brick wall"

The manager was supported by supervisors who worked in the field with carers and coordinators who worked in the office. There was an on call system which operated out of hours and was overseen by staff who worked in the office and they told us that they had access to electronic system and schedules which enabled them to informed advice. The carers were spoke with were positive about this and described it as a "good system." We saw that team meetings were held in the different locations and newsletters sent out. These served as mechanisms to update staff on changes and learning opportunities as well as reminders on expectations.

In the provider information return sent to us prior to our inspection (PIR) the provider told us they intended to make improvements to the service and they told us that that they planned to increase service user involvement in the service by implementing a service user forum. They told us that they intended to do this by September 2016 however this had not yet taken place.

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 Peoples medicines were not always being managed safely

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to assess, monitor and improve the quality and service were not working effectively.