Westminster Homecare Limited

Westminster Homecare Limited (Milton Keynes)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Westminster Homecare Limited (Milton Keynes) is registered to provide personal care for people who live at home in and around Milton Keynes and the surrounding villages. The service provides personal care for approximately 220 people.

This inspection was an announced and took place on 18 and 21 April, 10 and 12 May and 1 June 2016.

We had been informed the registered manager had recently resigned and a new manager had been appointed. A registered manager is a person who has registered with CQC 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.

Staffing arrangements had not always ensured sufficient staff were available to consistently respond to people's assessed needs.

The systems to oversee and manage people's medicines were not always effectively managed. The provider had not always identified areas requiring urgent action to be taken timely.

The provider had not worked in line with the principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS).

Staff respected people's privacy and dignity; they provided care that was caring and supportive of people's choices and preferences.

The systems for handling complaints were not sufficiently robust and the systems to monitor complaints lacked management oversight.

People were supported to have meals, snacks and drinks available to ensure they had adequate nutrition and hydration.

Risk assessments identified specific risks to people and hazards in their home environment.

Staff were knowledgeable of the safeguarding reporting procedures and knew how to respond to any abuse. The staff recruitment systems were robust. Comprehensive induction training and on-going training was provided for staff.

People and their representatives were involved in planning their care. The support plans contained sufficient information for staff to follow in meeting people's needs. People were supported to see health care professionals as required.

We identified that the provider was not meeting regulatory requirements and were in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 always safe.

The systems to oversee and manage people's medicines were not always effectively managed.

Staffing arrangements did not always ensure the right number of staff were available to consistently respond to people's assessed needs.

The recruitment processes were robust to ensure that only suitable staff were employed to work with people using the service.

Staff knew what protecting people from harm meant and how to safeguard people from abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

The principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards had not been followed in practice.

Systems were in place for staff to receive group support.

Staff received appropriate training and their knowledge and competency was regularly assessed.

People were supported by staff to eat and drink sufficient amounts according to their preferences.

Staff took prompt action to contact other health care professionals when required.

Is the service caring?

Good

The service was caring.

Staff were caring and compassionate.

Staff respected people's rights to privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The system for responding to and handling complaints at the service level was not sufficiently robust.

People were involved in their care planning as much as possible.

The support plans provided sufficient information on people's needs.

Is the service well-led?

Requires Improvement

The service was not always well-led.

At the time of the inspection the registered manager had submitted their resignation and a new manager had been appointed.

The requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) were not managed appropriately.

Staffing arrangements, medicines and complaints systems were not always managed appropriately.

People were involved in developing the service through face to face and telephone meetings carried out.

Westminster Homecare Limited (Milton Keynes)

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 registered manager 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 announced inspection took place on 18 and 21 April 2016 the 10 and 12 May and 1 June 2016 and was completed by one inspector. We gave the provider 48-hours' notice before we visited the care agency. This was to ensure that the registered manager and staff were available to facilitate the inspection and to ensure people knew we would be contacting them.

Before the inspection, the provider 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 looked at information we held about the service including statutory notifications. A notification is information about important events which the provider is required to tell us about by law. We also received information about the service from local authority commissioners involved in monitoring the care of people using the service.

During the inspection we spoke with five people using the service and four relatives. We spoke with the area manager, eight staff that included care and senior care staff, a care co-ordinator and the training facilitator for the service.

We looked at the care records for 15 people using the service, which included support plans, risk assessments and medicines records. We looked at six staff recruitment files and the staff training records. We also looked at records in relation to the oversight and management of the service, which included records of quality monitoring visits, feedback received from people using the service and records of compliments and complaints.

Requires Improvement

Is the service safe?

Our findings

Where the service was responsible for administering people's medicines it was not always managed effectively. One relative told us the provider had taken on the responsibility for ordering, collecting and administering their family member's medicines. However they expressed great concern that their family member had been without their prescribed pain relief medicine for a period of eight days.

The relatives concerns were immediately brought to the attention of the manager who arranged for them to be investigated. Initial enquiries made by the manager into the concerns confirmed that the person had gone without their pain relief over a bank holiday period. They told us this had happened due to the medicine being taken with the person, to the day centre and not returned. The manager confirmed the missing medicine had been obtained for the person.
Quality monitoring visits carried out by the service checked that people received their medicines as prescribed. However they lacked sufficient management oversight in ensuring that prescribed medicines were consistently available for people.

We also saw documentation was available within people's care files that listed the medicines they were prescribed. It was also recorded whether the person retained the responsibility for administering their medicines or whether the provider had taken on the responsibility.

One person said, "I take a lot of medicines, up to 12 tablets a day, the staff give me my medicines and sign the medicine chart after I have taken them. [Staff name] is exceptionally good, she should have been a nurse, she always checks to make sure the other staff sign the medicine charts properly".

Staff told us they had received training in medicines administration that included knowledge and competency assessments. This was also evidenced through training certificates and competency assessment records held within the staff files.

The provider told us that the Medicines Administration Records (MAR) were kept in people's own homes and that people's prescribed medicines were written up on the MAR charts by the district nursing staff. They said the MAR charts were considered to be the responsibility of the district nursing and they were therefore unable to archive the completed MAR charts at the agency office. During a home visit to a person using the service, we checked their MAR charts and found that the staff had completed them appropriately on administration of their medicines.

Assessments of people's dependency needs were carried out to determine the level of staff support people needed. For example, people that required two staff to assist them to safely move and provide their personal care. We received mixed responses from people using the service and relatives regarding staff availability. One relative said, "My [family member] has a live in carer; they are supposed to have the same member of staff for a month at a time. Recently the staff are being changed practically every week, with no notice or explanation as to why". They told us a member of staff was supposed to relieve the live in carer whilst they took a two hour break and also to help with moving and handling and personal care. However

they said the additional member of staff did not always turn up. They said, "I often end up having to help out myself, I shouldn't have to do this, I'm in my eighties".

Another relative said, "We used to get the staff rota sent to us, but this doesn't happen anymore, so we don't really know which staff to expect". One member of staff said, "Sometimes people have late calls, but they don't always realise this as the rotas are not always sent out to them".

Two people using the service commented that the staff often arrived earlier than agreed for example, 20 minutes or in some cases an hour earlier. One person said, "In the scheme of things I would rather they arrived earlier than later, but really they should come on or around the time we agreed". This meant that people had not always received the right level of staff support and visits had not always taken place at the times they had agreed.

Some people told us they were kept informed if their calls were to be delayed and the reasons for the delays. One person said, "The staff do generally arrive on time". Another person said, "Somebody from the office, usually contacts us to let us know if the staff are running late". Staff told us they were allocated sufficient time to travel between calls and tried to ensure they kept to the times. We saw that staff logged the arrival and departure times within the daily notes held within people's homes. We also saw that the calls were monitored electronically and audited during home visits carried out by the service.

Due to the mixed response regarding staff availability we brought the comments people using the service and their relatives to the attention of the manager. They told us that recent quality monitoring visits had also found similar concerns, and they were in the process of being further investigated.

People were protected from abuse. The comments received from staff indicated they had a good understanding of the importance of safeguarding people from abuse and they were knowledgeable of the safeguarding reporting procedures. One member of staff said, "I raised an issue under safeguarding and it was dealt with very quickly", another said, "I think we all know how to recognise poor care, I wouldn't hesitate to inform the manager if I ever witnessed or suspected any form of abuse". The staff confirmed that safeguarding training was covered during their induction training, and that regular safeguarding refresher training was provided for them.

The training lead for the service confirmed that all new staff were provided with in depth safeguarding training that covered the different types of abuse and the reporting procedures, including the whistleblowing procedures. We found that individual staff files contained safeguarding training certificates that also demonstrated the members of staff had attended the training.

We looked at records of safeguarding investigations held at the service. We saw that the provider had taken appropriate action to investigate the concerns and learn from them, working in collaboration with the local authority safeguarding team.

Relatives told us they thought their family members were safe using the service. We saw within people's care plans that risk assessments identified areas of specific risks to individuals and what staff needed to be aware of to ensure people's safety was promoted and protected. The risk assessments were reviewed regularly to make sure that the home environment was safe and the right equipment was available and used to enable people to safely maintain their independence. For example, identifying, slips and trips hazards and the type of walking and bathing aids needed. This ensured that any hazards were reduced to a minimum. We also saw that accidents and incidents were recorded appropriately and the care plans and risk assessments were updated to reflect any changes necessary.

The staff recruitment procedures were sufficiently robust to ensure that only suitable people were employed to work at the service. We saw a recent survey carried out by the provider, had asked people for their views on the suitability of the staff providing their care. One person had commented 'Congratulations to the person that recruited [staff name] they are remarkably capable'.

The staff confirmed that full employment checks were carried out on them before they started working at the service. They told us they included written references being obtained from previous employers, or personal references, for staff that had not been previously employed. We saw checks had been carried out through the government body Disclosure and Barring Service (DBS), which helps employers to make safer recruitment decisions and limits the risks of unsuitable people working with vulnerable groups, including children.

Requires Improvement

Is the service effective?

Our findings

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 the mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for domiciliary care services is called the Court of Protection.

We saw that some people's support plans recorded that they lacked the capacity to make decisions. However MCA assessments had not been carried out to demonstrate how the provider had reached this conclusion. For example, one person's support plan recorded that staff use 'some reasonable force' to stop them being attacked when providing the person with personal care. The staff told us that sometimes the person displayed physical aggression towards them, by grabbing out at them when providing personal care. However the support plan did not give any details of what the 'reasonable force' meant. We also found within another person's support plan it was recorded that staff needed to double lock their front door when leaving, in effect locking the person inside their home. We found no specific MCA assessments had been carried out to establish capacity and no best interest decisions had been made to make sure any restrictions placed on people were the least restrictive as possible.

This was a breach of Regulation 11(3) (4) (5) and Regulation 13 (7) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People using the service and their relatives told us that the staff sought their consent before carrying out their care and providing support. One relative said, "The staff always ask [family member] if they are in agreement before they do anything for them". We saw within people's care records that people or where it was not possible, their representatives had signed to give their consent to receiving care from the service. The staff told us they understood the principles of the Mental Capacity Act 2005 and the importance of seeking people's consent before carrying out any care tasks. They also told us they had received training on the MCA 2005 and we saw this was documented in the staff training records.

We received mixed views from the people and relatives we spoke with regarding the knowledge and skills of the staff. One person said, "I have no qualms about the staff, they do a good job". Another person said, "I always have two staff to help me, sometimes I have one experienced member of staff and a trainee comes with them. They seem to know what they are doing, I have a special bed and use a hoist and have never felt that they didn't have the experience". One relative mentioned three staff who they felt conducted themselves 'very professionally'. They said "They [staff] look after [family member] as if they were their own relative, I have every confidence they are fully competent to meet [family members] needs". In comparison, one relative thought that some staff that attended their family members care did not have the right skills to provide a quality service. For example, they said, "Some staff seem a bit 'heavy handed' with my [family member], especially when helping to wash and dress them and move position". They also said the same

staff did not always clear things away after they had finished providing care.

Staff told us that the training provided at the service was good. They said it mainly consisted of face to face training delivered by the training lead for the service. Records of staff training showed that staff were provided with mandatory health and safety training, such as, medicines management, infection control, food hygiene and training specific to meeting the needs of people using the service. For example, dementia care, Parkinson's disease, catheter and stoma care and pressure area care. Some staff had begun working towards the new Care Certificate diploma, as part of induction training. This is a set of standards that social care and health workers need to follow in their daily working life.

The staff told us that after their initial induction training they worked alongside experienced members of staff and then observed on a number of occasions to ensure they were competent to perform their duties.

The staff said they felt supported, one member of staff said, "There is always someone you can speak to in the office". They said they received one to one supervision with their supervisors, although the meetings were not always pre-arranged. One member of staff said, "I think I am supposed to have supervision every three months, but in reality it's more like every six months, they [senior staff] do try their best but it's not always easy to find the time". Another member of staff said, "If I felt I needed to speak to a supervisor, I could ask to have supervision".

Staff told us that they encouraged people to make healthy food choices and supported people to eat a balanced and nutritious diet, in keeping with their individual needs. We saw the staff recorded what people had to eat and drink. One relative told us they had concerns about the food and drink intake of their family member, saying they had lost a lot of weight. They said they were concerned that the staff did not always rotate the food provision so food was used within the best before and use by dates, as they had found food left in the fridge that had gone out of date. We brought their concerns to the attention of the manager who said they would address them directly with the relative.

Relatives told us they had been contacted by staff in response to any deterioration in their family member's health conditions, and that staff had called the GP in the event of medical emergencies. The staff said they worked well with community healthcare professionals, such as district nursing staff involved in people's care and followed the instructions of the healthcare professionals in meeting people's needs. We saw that the staff recorded within the daily notes when they had supported people to maintain good health, for example, assisting people to change position in bed and when seated to reduce the risks of developing pressure area ulceration.

Good

Is the service caring?

Our findings

We saw that people were asked to feedback on their experience of using the service and that most of the comments about staff were positive. One person commented that the staff had supported them to improve physically and mentally, and their support had made a positive effect on their lives. Another person commented that the support they received from staff had made it possible for them to return to work, and another said that the staff always showed them the 'utmost care and compassion'.

People using the service and their relatives told us they had good relationships with the staff that attended their care. They spoke highly of the attitude of the staff saying they treated people with kindness and compassion. One person spoke of how the staff supported them in meeting their intimate care needs, they said, "They are really good I sometimes feel embarrassed, they recognise this and help ease my anxiety. They treat me with dignity and respect; they allow me do things myself as much as possible, in my own time". One relative said, "The staff provides care for my [family member] as if they were their own, I can't speak highly enough of them".

The staff we spoke with were knowledgeable of people's individual circumstances and preferences, and how people wanted to be supported. They were able to give accurate accounts of how they provided care for people, which correlated with the information in the support plans.

We saw that people were asked if they had a preference as to whether they wanted male or female carers to provide their personal care and their preferences were respected.

Within the daily notes we good examples of when staff had responded to people's emotional needs. Such as, staying with people spending time to sit and chat, providing companionship to help alleviate isolation and loneliness.

People told us the staff addressed them by their preferred name. People and relatives told us the staff preserved their privacy and dignity when providing personal care. One person said, "They [staff] always make sure I am covered when I'm getting washed and dressed, they make sure my curtains and the door are closed".

Requires Improvement

Is the service responsive?

Our findings

We found the systems for handling complaints at service level were not sufficiently robust to ensure they were consistently responded to. Prior to our inspection a relative contacted the Care Quality Commission (CQC) to inform us about a complaint they had raised about the service. They also provided copies of documentation they had submitted to the service regarding their complaint. They said they had not received any acknowledgment of their complaint from the service and as such did not feel it had been taken seriously. They told us they had taken the decision to bring their complaint to the direct attention of Westminster Homecare Head Office, and it was currently being dealt with.

People told us that information on how to complain was available in the care files held within their homes and we also saw evidence of this when visiting people using the service. People and relatives told us they contacted the care agency if they had reason to complain about the service. Two relatives commented that they had tried to contact the agency office to discuss aspects of care provision they were unhappy about and their calls had gone unanswered. One relative said, "I have raised complaints on several occasions, but nothing seems to get done about them".

We looked at records of complaints held at the service. We found that one complaint had been recorded that was received in January 2016 and related to another matter. We were unable to find any record of the complaint that had been brought to our attention. We discussed this with the area manager who confirmed the complaint was currently being dealt with by head office.

This was a breach of Regulation 16 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service routinely asked people for feedback on the quality of the service they received and their feedback was acted upon. For example, we saw that people's call times had been adjusted upon their request. People and their relatives told us that home visits and telephone interviews were carried out regularly by care supervisors to seek feedback on the care they received. They said they were asked whether the staff arrived on time and stayed for their allocated time. We saw that one person had requested a change of staff and the provider had arranged for another member of staff to provide their care.

Assessments were carried out by the service to identify the areas where people needed care and support. People said they were aware of having a care plan in place; one person showed us their care plan and confirmed that the content accurately reflected their current needs. The support plans we looked at included information on the times and frequency of visits, the person's communication needs, their likes and dislikes hobbies and interests. Where possible, people or their representatives had signed the support plans to show their agreement with the content.

Requires Improvement

Is the service well-led?

Our findings

We were told that the registered manager had recently resigned and they had submitted their application to de-register with the Care Quality Commission (CQC). A new manager had been appointed and intended to register with CQC.
Quality assurance systems were used to monitor the service. They included home visits and telephone interviews with people using the service and their relatives. Spot checks to observe staff practice, knowledge and competency. Audits were also carried out on medicines, people's support plans, risk assessments and the staff recruitment and training records. However we found the monitoring of staff arrangements, medicines and complaints lacked management oversight. We also found the principles of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) were not being followed.

The staff said they worked well as a team. One member of staff said, "I enjoy working in the community no two days are the same, it's nice to help people to be as independent as possible and to stay in their own homes". They said the vision and values of the service and the expectations of providing high quality care was explained to them during their induction and they worked to uphold the values of the service. People were complimentary of the care they received from staff and said they had good relationships with them.

Regular staff meetings took place and provided a forum for staff to receive information from the provider. We saw that recent meetings had included staff being informed of updates to policies and procedures, the introduction of a new calls monitoring system. They were also reminded about the importance of signing documentation held in people's homes, such as, the Medicines Administration Records (MAR) and recording their arrival and departure times in the daily logs.

Staff said they felt supported. However we found the opportunities for them to meet with their supervisors to discuss in private, their work performance, learning and development needs, and other matters took place infrequently.

Accidents and incidents that happened in people's homes and in the agency office were appropriately recorded. The provider had taken appropriate action to reduce the risks of any repeat accidents. They had also informed the Care Quality Commission (CQC) of notifiable events as required by law.

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 11 HSCA RA Regulations 2014 Need for consent Where people's capacity was in doubt, processes were not in place to act in accordance with the Mental Capacity Act 2005

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Processes were not in place to fully protect people from the risks of being unlawfully deprived of their liberty.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The system for receiving, recording, handling and responding to complaints was not effectively operated at the service.