Westminster Homecare Limited

Westminster Homecare Limited (Norwich)

Inspection report

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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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection of Westminster Homecare Limited (Norwich) took place between 14 June 2018 and 2 September 2018. Our visit to their office was announced to make sure staff were available.

Westminster Homecare Limited (Norwich) is a domiciliary care agency that provides personal care to people living in their own houses and flats in the community. It provides a service to older adults. At the time of our visit 145 people were using the service.

Not everyone using Westminster Homecare Limited (Norwich) receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

There was a registered manager at this agency who was supported by an office staff and other senior staff. 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 our previous inspection we rated this service as Requires Improvement. The rating remains Requires Improvement at this inspection. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions Safe, Effective and Well-led to at least good.

The provider's monitoring process did not effectively identify issues or take action to resolve these, in particular in relation to medicine recording errors. Medicine administration records were not always completed correctly and this put people at risk that they had not received their medicines as prescribed.

Staff knew how to respond to possible harm and how to reduce most risks to people. There were enough staff who had been recruited properly to make sure they were suitable to work with people. Staff used personal protective equipment to reduce the risk of cross infection to people.

People were cared for by staff who had received the appropriate training and had the skills and support to carry out their roles. Staff members understood and complied with the principles of the Mental Capacity Act 2005 (MCA). People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People received support with meals, if this was needed.

There was enough information for staff to contact health care professionals if needed and staff followed the advice professionals gave them.

Staff were caring, kind and treated people with respect, although the agency did not always respect people's right to be cared for by staff of the gender of their choice. People were listened to but were not always asked about their care. People's right to privacy was maintained by the actions and care given by staff members.

People's personal and health care needs were met and care records were in place and contained enough information to guide staff in how to do this.

A complaints system was in place and there was information available so people knew who to speak with if they had concerns. Staff had adequate guidance and support to care for people at the end of their lives, if this became necessary.

People's views were sought but no action was put into place to improve issues that were raised.

Staff were supported by and supportive of the registered manager and office staff.

We found a breach of Regulation 12 and of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to medicines management and to the governance of the agency. You can see what action we told the provider to take at the end of this report?

Further information is in the detailed findings below

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.

Medicine administration records were not accurately completed and medicines were not always given as prescribed.

Staff assessed risks to protect people from harm and followed infection control practices to reduce the risk of cross infection.

There were enough staff, who had undergone recruitment checks, available to meet people's care needs.

The systems in place to learn lessons from incidents were completed effectively.

Is the service effective?

Good

The service was effective.

Systems were in place to make sure people's care and support was provided in line with good practice guidance.

Staff members received enough training to provide people with the care they required.

People were supported eat and drinks as independently as possible.

Staff worked with health care professionals to ensure people's health care needs were met.

Staff supported people to continue making decisions for themselves.

Is the service caring?

Good

The service was caring.

Staff members developed good relationships with people using the service and their relatives, which ensured people received the care they needed.

Staff treated people with dignity and respect and people's preferences were not always respected.

Is the service responsive?

Good

The service was responsive.

People had their individual care needs planned for.

People had information if they wished to complain and there were procedures to investigate and respond to these. Informal concerns were not monitored for trends and themes.

Guidance was available staff about how to care for people at the end of life.

Is the service well-led?

Requires Improvement

The service was not always well led.

The quality and safety of the care provided was not effectively monitored to drive improvement and it failed to identify and address issues and shortfalls.

People's views about the agency were obtained and action was taken to address issues.

There was a good working relationship between staff members and people.

Staff contacted other organisations appropriately to report issues and provide joined-up care to people.

Westminster Homecare Limited (Norwich)

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 between 14 June and 2 September 2018, and was announced. We gave the service 48 hours' notice of the inspection visit to make sure the registered manager or another senior staff member was available.

Inspection site visit activity started on 14 June 2018 and ended on 2 September 2018. It included looking at care and medicine records, and reviewing the agency's policies and procedures. We visited the office location on 14 June 2018 to see the manager and office staff and to review care records and policies and procedures. We spoke with people and with staff between 14 June and 2 September 2018.

This inspection was carried out by two inspectors and an expert-by-experience in care for older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection, we reviewed the information available to us about the service, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law.

We spoke with eight people using the service and two people's relatives. We spoke with four members of care staff, the registered manager and the provider's operations manager. We checked six people's care records and medicines administration records (MARs). We checked records relating to how the service is run and monitored, such as audits, staff recruitment, training and health and safety records.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in February 2017 we found there was breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Risk assessments were not completed in sufficient detail to reduce risks to people and were not reviewed when there were changes to people's needs. Medicines were not always given as prescribed and staff did not always complete Medicine Administration Records (MAR). Not all of the required checks and information was obtained for new staff before they started working for the agency. The provider wrote and told us that they would take action to improve by auditing and reviewing MAR and care records, and providing additional training for staff.

At this visit we found that although the provider had made some improvement to this area, it was not enough and medicine management and recording continued to be of concern. Medication administration records (MARs) were not always completed properly and there continued to be missed entries and a lack of explanation for this. The MAR for one person showed that their pain-relief patch was not applied as often as it was prescribed to be and that on one occasion it was delayed by one day, and by three days on two other occasions within a 28-day period. There was no information available to staff to ensure that these medicines were applied effectively and in a way, that kept people safe; records did not demonstrate where on the body these medicines were applied each time. The site of application of a patch should be rotated with each application to protect the skin and ensure the correct rate of absorption. Records would also ensure patches were located and removed before a new patch was applied and reduce potential risk of overdose.

Audits of medicines and medicine records failed to identify these shortfalls. We spoke with the registered manager about this during our visit and they put the organisation's guidance and recording form in place immediately. These records had been available, although they had not been put into place or used prior to our identifying this concern.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who needed support with their medicines received this from staff who had received training to be able to give medicines. To ensure that it was clear who the medicine was prescribed for, information, such as identification, specific administration instructions, allergies and contact details for each person's GP and pharmacy, was also available. Information about how people preferred to take their medicines was also recorded in care plans and this gave staff clear advice about how to do this.

Risks to each person were assessed, reviewed and actions were identified to reduce those risks. These included moving and handling risks during showering and bathing. Information was available to guide staff if people had a health condition, such as epilepsy. These included details of how to support the individual and keep them safe during a seizure.

Environmental checks of people's homes were completed. They provided staff with an overview of where there may be potential risks to health and safety, such as manoeuvring moving and handling equipment on

carpeted floors. Strategies were in place for staff to minimise risks. Staff ensured equipment was regularly serviced and maintained.

Recruitment files showed that satisfactory checks were completed before the new staff member worked with people. A staff member confirmed that they were unable to provide care to people until all checks had been carried out and were satisfactory. These included criminal record checks (DBS), identification and references from the most recent employer to ensure that they were safe to work. New staff completed induction training and shadowed more experienced staff so that they understood how to keep people safe while giving care and support. A staff member told us that they had been offered more shadowing shifts when they first started working for the agency to ensure they were competent.

People told us that they felt safe with staff from the agency. One person told us, "Certainly, yes definitely." They said this was because staff were "thorough." Another person said, "They do things in a safe and proper way." Staff knew how to protect people from harm; they told us they had received training, they understood what to look for and who to report to. Information about keeping security of people's homes was included in care records. Information received before our inspection showed that the registered manager had reported safety incidents as required, and staff had taken appropriate action to protect people and reduce risks to their safety and wellbeing. The registered manager was aware of their responsibility to report issues relating to safeguarding to the local authority and the CQC.

People told us that there were enough staff and they stayed until they'd completed all of the tasks they needed to. However, three people also told us that staff were sometimes late, which meant people did not always receive their care when they expected. Staff told us that although they sometimes had a lot of staff and sometimes less staff, they were never short of staff. The registered manager told us that there were additional staffing hours each week (where staff had said they were available to work) that meant sudden or extra care tasks could be accommodated. A staff member also commented that the agency frequently recruited new staff members to ensure there were enough staff.

Processes were in place to reduce the risk of infection and cross contamination. Staff told us that they had enough personal protective equipment (PPE) available such as gloves and plastic aprons to help prevent cross infection during their visits from one person to another. They had received training in infection control and prevention, which provided them with the skills to reduce risks to people. Care records also guided staff in how to reduce these risks. For example, with reminders and prompts to use gloves and other protective equipment, and to wash their hands. This showed us that processes were in place to reduce the risk of infection and cross contamination.

Incidents and accidents were responded to appropriately at an individual level and information about these fed into the provider's monitoring system. However, the analysis of these incidents did not clearly identify trends or themes. In response to this the organisation's policy had been changed, which led to managerial staff taking additional action to support staff to change their practice. This resulted in closer monitoring of staff to ensure poor practice did not continue.

Good

Is the service effective?

Our findings

At our previous inspection in February 2017 we found there was breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff did not always act within the principles of the Mental Capacity Act 2005 (MCA). Mental capacity assessments had not been carried out for people prior to decisions being made on their behalf about their care and support. The provider wrote and told us that they would ask for mental capacity assessments to be completed, provide staff with further training and obtain copies of Lasting Power of Attorney where required.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA and found that there had been an improvement in this area. Staff had a good understanding of the MCA and worked within its principles when providing care to people. One staff member explained that they had received training and always presumed people were able to make their own decisions. Another staff member told us that they always informed people what they were going to do and waited for the person to say they were happy for the staff member to continue.

Staff could access guidance to help people continue to make their own decisions. They supported one person by prompting the person to take their medicines, although these were sometimes refused. This approach was in their best interest and was the least intrusive way to support them. The decision was agreed following consultation with the multi-disciplinary team and the person's family. Copies of Lasting Power of Attorney authorisations were also available in people's care records and these showed which decisions others could make for the person.

Needs assessments were completed for people using the service before their care started. They were completed with the person and/or their families and included information from health and social care professionals, where available.

The registered manager told us that staff ensured people had any technology that promoted independence, such as pendant or wrist alarms, close to them. Care records also included prompts to staff to ensure people had these items before the staff member finished their visit. This enabled people to summon for help in an emergency when they were alone.

Staff felt that they received enough training and support to give them the skills to carry out their roles. They said they were able to get additional training if needed and they were able to complete national qualifications in care. One staff member commented that the dementia training they had received had

"made a huge difference". They went on to say that, "I found out stuff that I didn't know and this has helped when caring for people." Staff training records showed that staff members had received training and that competency checks for medicines administration were completed.

Staff members said they received support from the registered manager and other staff to do their jobs. They explained a care supervisor regularly visited people's homes while they were working to carry out spot checks and this provided an opportunity for them to discuss any practical issues they may have. Staff also received individual support meetings with a member of the management team to discuss training and development needs and any ongoing issues in their day to day work. One staff member explained how concerns they raised at one of these meetings was addressed by their senior and satisfactorily resolved.

We saw that, where needed, people were supported to eat and drink. One person told us that although they did not eat a lot, staff always made their breakfast and lunch, and left snacks for them during the day. Staff were aware of the appropriate actions to take if they had concerns about a person's eating and drinking. Staff told us they ensured people had enough to drink during the day and checked they always had water available. Care records contained information about people's likes, dislikes and what staff needed to do to support the person in relation to eating and drinking. Where a person had swallowing difficulties, placing them at risk of choking, their records provided staff with information on how to use a thickening agent in their drinks. This made it the correct consistency to swallow minimising their risk of choking.

The registered manager told us that they had good working relationships with health and social care professionals and worked closely with them to ensure a smooth transition when people required a hospital admission or discharge. The provider organisation was in the process of developing a written record, such as a hospital passport or 'This is me' form. These documents contain important information about the individual that would help health professionals to communicate with them and support them more effectively.

People's care records showed that they had access to the advice and treatment of a range of health care professionals. These records provided enough information needed for staff to contact health professionals and to support people with their health needs, if needed. One person's records included guidance from a health professional to enable staff to recognise and respond if their health condition deteriorated. Staff members told us how they had contacted health professionals, such as GPs and district nurses when they were concerned about people or when people had requested this.

Good

Is the service caring?

Our findings

People told us that staff were kind and caring. People told us staff were "… all without exception very impressive and very understanding" and "caring people." One person said, "If I didn't like them, I would not have gone back to them. I went to hospital and then when I came home I had the [staff] back again." Another person described how staff engaged them in conversation about the person's life and how they enjoyed this.

Care records had details about how people wanted to be addressed, their likes and dislikes and their preferred routines. We found that staff knew people well and that they could anticipate people's needs. One staff member told us they used other methods to communicate with a person who was unable to communicate verbally. They explained how this made sure their care and support was in keeping with the person's wishes. Another person told us that they spoke with care staff directly if there was anything wrong and that this worked for them. One person had requested a change of staff member, "We just didn't gel. [Staff member] didn't do anything wrong, but I asked the office not to send them and they stopped sending them."

One person told us that they were aware of their care plans and staff spoke with them about how they wanted their care given. Both relatives that we spoke with said that they were aware of people's care plans. One relative said, "They got the plan right". People signed their care plans to acknowledge the information reflected their care needs and their wishes for how staff should support them.

Staff respected people's right to privacy and treated them with respect. This was clear in the way staff spoke about people, with thoughtfulness and concern. Staff told us that they greeted people before entering rooms, knocked on doors and called people by their names. Curtains and doors were closed when people received personal care and people were covered as much as possible when receiving a wash.

We saw that care records were written in a way that reminded staff to consider people's right to privacy and dignity whenever they provided care and support. For example, in advice about caring for specific needs around continence or personal care, staff were guided to make sure each person received this in a way they were comfortable with. One person's care records also gave guidance for staff in regard to the person's pet, which played an important role in their life by providing companionship.

Good

Is the service responsive?

Our findings

At our previous inspection in February 2017 we had concerns that not all care plans were written in enough detail to provide staff with the guidance to care for people properly. At this visit we found that there had been an improvement in the way care plans were written and the level of detail that informed staff how to provide personalised care that was responsive to the individual's needs.

Care plans provided clear written guidance for staff members in a step by step format. Information included why people needed the care and support they received, the difficulties the person experienced, what they needed help with and how staff should do this. Care plans were personalised; they included information about the individual's life, their hobbies, interests, how emotional needs could sometimes affect them and how staff should respond in these situations.

There were also care and support in relation to people's health conditions, such as diabetes. They provided clear guidance for staff on signs and symptoms to be aware of if their condition deteriorated and what to do to help them. Staff we spoke with had a good understanding of people's needs. Care plans were reviewed and revised every six months or when new areas of support were identified and changes needed. Staff wrote daily records to show people had received care and support in line with their support plan.

People told us that they received the care they needed, in the way they wanted. One person commented, "I haven't got anything to say about the [staff] not doing their jobs. They're doing everything fine." Another person said, "I'm satisfied with the [staff] who come - they don't do a lot, but they do it properly." A relative told us how staff spent time speaking with their family member about activities they used to take part in, such as painting. They said their family member enjoyed these discussions and how it made them feel. Staff had a good knowledge of people's needs and could explain how they provided personalised support to each individual.

People and relatives told us that they knew how to make a complaint and who to contact for this. One person said, "In four and a half years I haven't made a complaint. They never let me down." Only one of the people we spoke with had made a formal complaint, which they said was responded to and resolved to their satisfaction. Staff said they were confident the registered manager would deal with any given situation in the right manner. There were copies of the complaints procedures in each person's care records. Records showed complaints were investigated and actions were taken to resolve them and learn from them.

The organisation had a policy and procedure for end of life care in place to inform staff of the actions required of them to ensure people's needs at this time are met appropriately. There was no one at the time of this visit who was receiving end of life care and people's care records were not all completed with advanced planning for their end of life care preferences. The registered manager confirmed that end of life care had previously been provided by staff. One staff member told us that they had found this "very rewarding" work. The registered manager confirmed that the agency was supported by an organisational palliative care team from whom they could request guidance and advice.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in February 2017 we found there was breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Although there were systems in place to assess the quality of the service and risks to people, they were not effective. . The provider wrote to us following that inspection and told us that they would improve the quality assurance systems and monitor people's care more closely by telephone and home visits. They also told us that they would provide staff with care planning training. .

At this inspection visit we saw that there had been some improvement in all areas where we previously had concerns, however further improvement was still required.

Processes and systems in place for monitoring the quality and safety of the service were not operated effectively. Audits did not always identify failings and areas of recurring areas of risk, such as medicine management. They did not give clear information of actions required, who was responsible for carrying them out, the timeframe for completion or how outcomes should be monitored and maintained. Without this oversight the provider had failed to ensure that improvements were being embedded, capable of being sustained and that future shortfalls would be identified, appropriate action taken and lessons learnt.

Whilst the registered manager told us that there had been a reduction in the number of medicine recording errors by staff we found serious concerns that had not been identified and addressed. Which meant the registered manager or others could not be assured that people were receiving their prescribed medicines and not at risk because they were not.

A staff performance monitoring visit identified a staff member was late for their care visit. They also failed to look at the care plan to check for any changes in their care needs or care plan prior to delivering care. This potentially could place the person at risk of receiving inappropriate or unsafe care. The monitoring visit record did not show what action had been taken to address this.

An audit for another person's daily notes identified where staff who had not fully completed parts of their records. However, it failed to follow up comments that staff had made in the daily notes about the person that indicated a possible worsening of the person's condition. This meant that the audit was looking for specific things but did not look at the quality of the notes being written or the information contained within them.

Although the agency asked for people's views, the action taken did not improve the people's experience. Questionnaires had been sent to people and their relatives and had been collated into a report in September 2017. Most people were happy with their care and how the agency worked. However, approximately a quarter of the people who responded to the questionnaire were not happy with the communication they received from office staff if care staff changed or were going to be late. An action plan had been completed and included a reminder for staff to inform office staff and for office staff to contact people or follow up with a courtesy call. However, people told us during this inspection that they were still

not always told if staff were going to be late, which meant that the actions to improve from questionnaire were not effective.

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

People told us that they would recommend this agency to others. This was because the staff were nice and they were satisfied with the care they received. One person told us, "Yes, I would recommend this company. I'm impressed by it - they respond to your requests." Staff told us that the registered manager and office staff were approachable and they could discuss any issues with them. One staff member told us, "I have a good relationship with the office." Another staff member said that the organisation would support them to change things for people.

There was a registered manager in post, who was available for our visit to Westminster Homecare Limited (Norwich).

One staff member told us that staff roles and responsibilities were discussed at staff meetings. Another staff member confirmed that these meetings occurred every ten weeks or so and provided staff with the opportunity to discuss concerns. They also said that they had completed staff surveys and one staff member told us that they had been emailed with the results and an action plan.

Information available to us before this inspection showed that the staff worked in partnership with other organisations, such as the local authority safeguarding team. We saw that the registered manager contacted other organisations appropriately and in relation to safeguarding, took action where this was required. We saw that information was shared with other agencies about people where their advice was required and in the best interests of the person.

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 People who used the service were not always protected against the risks associated with the administration of medicines.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People who used the service were not protected against the risks associated with unsafe care because of inadequate assessment and monitoring of the risks relating to health and welfare.