Westminster Homecare Limited

Westminster Homecare Limited (Enfield/Waltham Forest)

Inspection report

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Date of inspection visit:
30 August 2016
31 August 2016
01 September 2016
05 September 2016
09 September 2016

Date of publication:
18 January 2017

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 took place on 30 and 31 August and 1 and 5 September 2016. We gathered all information from staff and people that we spoke with following the inspection by 9 September 2016. This inspection was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we wanted to ensure someone would be available to assist us with the inspection.

Westminster Homecare provides support and assistance for people who want to live at home and maintain their independence. They provide a wide range of personal care options and specialise in supporting people with dementia.

The service was last inspected on 04 February 2015 at their old location (Southbury House, 280-286 Southbury Road, Enfield, Middlesex, EN1-1TR). At our last inspection we did not identify any breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, we gave a recommendation around the service failing to not have completed a risk assessment for one person using a high-risk medicine. We recommended that the service review and implement national guidance, such as the National Patient Safety Agency anticoagulant and NICE guidance, with regards to the use and risk assessments for people prescribed anticoagulant medicines such as warfarin. At this inspection, we found that the service was still failing to complete risk assessments around high-risk medicines.

A registered manger was in place. A registered manger is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of law; as does the provider. The registered manager was present during our inspection.

Risk assessments were not always in place for identified risks. Risk assessments had not been completed for issues such as high risk medicines and known, significant health conditions. There were some risk assessments in place around manual handling. However, these did not always identify specific risks or provided care workers with enough information to mitigate those risks.

Medicines were not being managed safely. People told us that they received their medicines. However, medicine administration record often showed omissions in care workers signing for people's medicines. The provider was unable to tell us if these omissions were where medicines had not been given or care workers had given medicines and forgotten to sign. There was a risk people may not have received their medicines. Medicines audits did not always identify these issues.

There were numerous late visits and people told us that care workers were regularly late. Staff were not always given travel time by the office in order to ensure staff were not late. This had not been identified or addressed by the provider.

Systems for auditing were in place and completed by the operations manager. However, audits failed to adequately identify issues that were found during the inspection.

The culture was not open and transparent. Whilst some staff said they felt supported, other staff felt their views were not listened to and that management was not accessible or supportive.

Some people received a continuity of care. The provider always tried to ensure that the same care workers looked after people. However, this did not always happen and some people and relatives said that they always had different carers and did not know who was going to be attending the care visit.

Staff had a good understanding of safeguarding and were aware of how to recognise and report abuse.

There was a system in place to monitor any missed visits. Missed visits were investigated and action was taken. The provider had an electronic monitoring system to monitor visits in Waltham Forest. There was no electronic monitoring system in Enfield and office staff completed monitoring visits and phone calls for people that were supported within the borough. Monitoring visits allowed the service to get from people and relatives.

People were encouraged to have input into their care and the service. The provider was beginning a service user forum where people would be encouraged to discuss issues and say what they did and did not like about the service they received. The first meeting was due to take place 19 September 2016.

People were involved in decisions about their care. Where people were assessed as not able to make certain decisions, best interests meetings and decisions on their behalf were made and recorded. Staff had an understanding of the systems in place to protect people who could not make decisions and followed the legal requirements outlined in the Mental Capacity Act 2005.

People and relatives said that they were treated with dignity and respect. Staff were able to give examples of how they ensured that they promoted dignity. People were encouraged to be as independent as possible.

Staff received regular supervision and attended three monthly team meetings.

The service operated an on-call system for issues that arose out of hours. People said that they were able to contact someone in case of an emergency.

At this inspection we found breaches of Regulation 12, 16 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Care Quality Commission is considering the appropriate regulatory response to address some of the concerns we found during this inspection. We will publish what action we have taken at a later date. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Risks around health conditions had not been identified or risk assessed. Risk assessments around manual handling were brief and failed to provide care workers with adequate guidance on how to mitigate risks for people. Risk assessments for people using high-risk medicines were not always in place.

Records for administering medicines often had omissions. The service was unable to demonstrate if people had missed their medicines or if care workers had given medicines and not signed the records.

People experienced a high rate of late care visits and in instances were not informed if care workers were running late.

Care workers were able to tell us how they could recognise abuse and who to report to.

Is the service effective?

Good

The service was effective. Staff had on-going training to effectively carry out their role. People were supported by staff who reviewed their working practices as staff received regular supervision.

Staff understood their responsibilities in relation to meeting the requirements of the Mental Capacity Act 2005 (MCA).

People's food and dietary preferences were noted in their care plans. Where care workers supported people with food, care workers were aware of people's preferences and needs.

Peoples healthcare needs were monitored and referrals made when necessary to ensure their wellbeing.

Is the service caring?

Good

The service was caring. People felt that they were supported and staff understood people's needs.

People were treated with respect and staff maintained privacy

and dignity.

People were supported to make informed decisions about the care they received.

Is the service responsive?

Good

The service was responsive. Complaints were responded to in an effective and timely manner.

People's care, around what staff needed to do during care visits, was person centred and planned in response to their needs.

People and relatives were involved in planning their care.

Staff were knowledgeable about individuals support needs and their interests and preferences.

Is the service well-led?

Requires Improvement

The service was not always well-led. There was not an open and transparent culture within the service and staff did not always feel that the registered manager was supportive or accessible.

Audits and surveys were carried out to assess the standard of care. However, these failed to identify issues that we had identified during this inspection.

Complaints were not analysed for learning, trends and to make continuous improvements.

There was an effective on-call system in place and people were able to receive help out of hours where needed.

There were regular staff meetings where staff were able to discuss their role.

Westminster Homecare Limited (Enfield/Waltham Forest)

Detailed findings

Background to this inspection

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

This inspection took place on 30 and 31 August and 1, 5 and 9 September 2016. The inspection was announced. The registered provider was given 48 hours' notice because the location provides a domiciliary care service and we wanted to ensure someone would be available to assist us with the inspection.

This inspection was carried out by two inspectors and three experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The experts by experience supported this inspection by carrying out telephone calls to people who used the service and their relatives.

Before the inspection we looked at information that we had received about the service and formal notifications that the service had sent to the CQC. We looked at 37 people's care records and risk assessments, 25 staff files, 18 people's medicines charts and other paperwork related to the management of the service. We spoke with 21 people who used the service, 19 relatives and 22 staff. With people's permission, we also visited six people in their own homes.

Requires Improvement

Is the service safe?

Our findings

Risk assessments for people taking high-risk medicines were not always in place. High-risk medicines are medicines that can have significant and serious side effects. On reviewing care plans, we noted that five people were taking Warfarin. Warfarin is a medicine that is prescribed to thin the blood and is classed as a high-risk medicine as it can lead to serious side effects including excessive bleeding if the person cuts themselves. However, in three people's care plans there were no risk assessments in place or guidance for staff. Some care workers that we spoke with were able to tell us what side effects and risks were around people taking Warfarin. However, other care workers had no understanding of the risks. Another person was taking Alendronic acid, used to treat osteoporosis. This medicine is always prescribed to be taken once a week and has specific guidance on administration as it can severely irritate the digestive tract. There was no risk assessment in place and no guidance for staff on how to ensure that this medicine was administered correctly. We discussed this with the registered manager who was unaware that this was a high-risk medicine.

There were no risk assessments in place for people where the service had identified known risks. This included, alcohol dependency, behaviour that challenged, risks relating to dementia, epilepsy, swallowing difficulties, falls, serious mental health conditions, and other significant health conditions that people had been diagnosed with.

Care workers that we spoke with were able to tell us what people's risks were if they worked with them on a regular basis. However, where care workers were attending visits with new people, some care workers said that they did not always know the person's risks.

Risk assessments around moving and handling were not detailed and did not provide staff with sufficient guidance on how to mitigate known risks. Of the 37 care plans that we looked at only three had detailed information and risk assessments to enable staff to mitigate risks associated with moving and handling. Care workers that we spoke with told us that they felt their training had been good around moving and handling and they were confident on how to move and handle people appropriately.

Where people had been prescribed 'as needed' medicines, there were no risk assessments or guidance for staff on when to administer these medicines. As needed medicines are medicines that are given for things such as headache or constipation. They can also be medicines prescribed by the GP for specific issues.

There were significant concerns that the service was failing to adequately risk assess people's risks and all risk assessments that we looked at had concerns around their quality and content.

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

We asked the registered manager to inform us how the issue we had identified around risk assessments would be addressed within 72 hours of the inspection. The registered manager sent us an action plan

detailing how the service would review all 371 people that the service worked with and a date for when this would be completed. The registered manager told us that each person's care plan and risk assessment would be reviewed within two months and Field Care Supervisors (FCS's) would be given time to ensure that this was completed.

Medicines were administered in people's homes and staff returned the Medicine Administration Record (MAR) sheets to the office. However, this was not done regularly and we found that completed MAR charts were often not in people's care files. There was no clear system in place for care workers to return the MAR charts to the office on a regular basis.

During the inspection we saw that where care workers administered medicines from blister packs, the MAR chart stated 'Blister pack' and care workers signed to say that that dose, morning , lunch and/or evening, regardless of how many medicines there were had been administered. Individual medicines were not listed on the MAR chart but there were lists of people's medicines in their care plans. Where we found that there were omissions in signing service users MAR charts this related to all medicines that the service user was taking.

Of the 18 MAR charts that we looked at, we found that there were a significant omissions in signing for medicines in 12 cases to confirm that medicines had been administered. For one person there had been 53 omissions in signing over a three month period during September, October and November 2015. Another person's MAR chart showed 38 omissions in signing for their medicines over a seven month period. MAR charts failed to note why these medicines had not been signed for and or administered. When we spoke with care workers, they were able to tell us what they would do if medicines had not been signed for and told us that they would contact the office. Where we found omissions this was often where care workers had signed for the 'blister' pack having been administered. Whilst some auditing picked up the omissions in signing, there was no information around whether these people had missed their medicines or if they had been administered and not signed for. The registered manager was unable to tell us whether people had received their medicines as prescribed. This meant that there was a risk people may not have received their medicines and that this could impact on their health.

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

FCS's told us that staff were only allowed to administer or supervise medicines once they had completed medicines training. Staff were also observed in the person's home by more experienced staff before being allowed to administer medicines alone. People's medicines had been recorded in their care plans. Training records showed, and care workers confirmed, that they received medicines training during their induction and this was updated yearly. Staff received regular, documented monitoring visits and where they were administering medicines this was observed and their competency checked. If any issues were identified, care workers were spoken to and received further training.

The majority of people that we spoke with said that they regularly experienced late calls. Comments we received from people included, "They [care workers] are meant to come around at 09:00 but they come between 07:00 and 12:00. They don't tell me anything; I have to call to find out what is going on", "No [care workers do not come on time]. In the last year they always come around at different times", "I don't think they have ever been on time", "Morning ones are usually ok but the rest are random. No one calls me" and "No they don't [come on time] this morning they are meant to come around at 08:30 but they don't come today and I went shopping and when I got back at 12:15 they were waiting on the doorstep." However, other people said that carers were on time and called them if they were running late. This was generally where

people had regular carers.

Some staff that we spoke with said that they were not allocated time to travel in between visits and were booked with 'back to back' care visits. We looked at eight staff rotas and how care visits were organised by the office. On seven of the rotas viewed, there were back to back visits noted for the care workers. In one case a care worker had six back to back visits in a row. One care worker told us, "Mostly I have back to back calls. Very rarely do you get travel time to get there [to care visits]. It can be difficult coordinating the calls because there's no travel time so I'm often running late." Another care worker said, "I don't always have enough time to travel between jobs, Westminster Homecare don't put it on the rota or allow for traveling". We discussed this with the registered manager at the time of the inspection. The registered manager told us that the service tried to book care workers to visit people in the same area so that there was less travelling time.

Some people using the service received rotas of with the name of care workers that would be visiting and at what times. However, some staff told us that this was not common practice. People that we spoke with did not always know who was visiting unless they had regular carers.

For people receiving care in the Waltham Forest area there was an electronic monitoring system so that all missed or late visits were reported to the office electronically. Care workers had to log in and out through the telephones in people's homes. This also ensured that the office knew that care workers had stayed for the correct amount of time. The service then sent a weekly report to Waltham Forest brokerage team of all missed visits. For people receiving care in the Enfield area there was no electronic monitoring system in place. The office relied upon care workers to inform the office if they were running late so that they could inform the person or they relied on people calling in to the office to let them know that a care worker had not arrived. There were records of telephone monitoring for Enfield clients on a regular basis to check if care staff are arriving on time. However, documentation viewed during the inspection did not pick up late visits as an issue.

Late calls meant that people were not receiving care as agreed in line with their care package. People were experiencing issues such as late medicines, not being got up and dressed on time and not receiving food and drink at the correct time. This put people using the service at risk of harm.

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

A missed visit log was kept for both Waltham Forest and Enfield areas. There were ten missed visits in June 2016, none in July 2016 and six in August 2016. If a missed visit was reported, the service fully investigated why the missed visit had happened. Details of missed visits were kept including the person's name, date an apology letter was sent and the how the issue was resolved.

Feedback from people and relatives around how safe they felt being supported by staff from Westminster Homecare was generally positive and they felt that the care workers were dedicated and trustworthy. People said that they felt safe with the care staff that visited them. People told us, "Yes I feel safe. The regulars are good", "I've not had any reason not to trust them yet" and "Yes they the carers are really good."

Care workers that we spoke with were able to explain how they would keep people safe and understood how to report it if they felt people were at risk of harm. Care workers were able to explain different types of abuse and how to recognise it. One care worker said, "Different types of abuse include physical, sexual and emotional. I would report it to my manager. If I go to my client and I see bruises I will ask what happened to

them and then I will report it." Another care worker said, "It [safeguarding] is making sure that the service user is in a safe environment, not suffering abuse from family, neighbours or staff or being taken advantage of. If there are concerns I would let the office know and if they did nothing I would go to the next level such as social services." Staff told us and records confirmed that they were trained in safeguarding during their induction.

The service kept detailed records of when safeguarding issues had been raised to the local authority. The service also documented the outcome of any investigations. Where action needed to be taken by the service, this was documented. Some actions included, re-training care workers, disciplinary action and contact with the person the safeguarding was about. We spoke with the local safeguarding team who told us that the service was, "Good with reporting safeguardings and transparent and not defensive" when safeguarding issues were raised.

Staff were aware of what whistleblowing was and how to report concerns. One care worker said, "I would tell my manager that if you don't do anything I will take it to a higher manager or CQC (The Care Quality Commission).

The registered manager had put in place a risk management system to identify people who needed critical care visits that could not be missed. There were contingency plans in place to ensure that people received care in case of emergencies, such as extreme weather conditions.

The service followed safe recruitment practices. Recruitment files showed pre-employment checks, such as two or three satisfactory references from their previous employer, photographic identification, their application form, a recent criminal records check and eligibility to work in the UK. Staff did not start providing personal care until pre-employment checks had been made. This minimised the risk of people being cared for by staff who were inappropriate for the role.

Good

Is the service effective?

Our findings

Care workers told us and records confirmed they were supported through regular supervisions, usually every three months. Care workers also told us, and records confirmed that where they had been employed for a year or more, an appraisal had been completed.

Staff said that they generally felt supported by the Field Care Supervisors (FCS's). Care workers said, "They do support me. If there is anything you call them and they will support", "My FCS will help if I call her" and "They (FCS) do listen to my feedback. I told them I needed more training for medication which they provided."

On commencing employment, care workers undertook a 12-week induction programme including five days of classroom based learning prior to starting to work alone with people. This covered all mandatory training in areas such as moving and handling, person centred care and dementia awareness. The service had a separate training room which also had a bed and a hoist to facilitate practical training sessions in manual handling. Shadowing assessments were seen on files with the provision of a minimum of eight hours shadowing for each new starter. All care workers that we spoke with said the training was satisfactory and that they undertook refresher training as required.

The service had a dedicated training manager that provided all training within this branch of Westminster Homecare and worked at the service five days a week. The training manager told us that he devised and delivered a five-day induction training package and had developed all of the training materials and information sheets provided to staff during training.

Training certificates were seen with competency assessments for training in medicine, moving and handling. Training was seen to be refreshed on an annual basis. Records showed that the service completed direct observations of staff on the job on a regular basis. Where FCS's were undertaking observations of staff in people's homes, the service wrote to people to let them know that they would be doing this.

The Mental Capacity Act (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisation to deprive a person of their liberty were being met.

There were two sections within people's care files where consent to care could be obtained. One was part of

the service user agreement handbook and one was within the care and support plan. People and/or relatives generally signed one or both of these forms. The service user agreement handbooks we looked at had been generally been signed by either the person receiving care or a relative. However, where a person was unable to sign and there was no relative present, there was no reason provided as to why the person was unable to sign or whether they lacked capacity to sign. People told us that care workers generally asked for consent before carrying out any care, "They offer to help me with going to the bathroom but I can usually help myself with my walking stick but they ask", "They do ask if I want to do something now or later" and "They don't force me into doing anything."

Staff received training in the MCA during their induction as part of dementia awareness. The service ensured that care workers refreshed this training annually. The majority of staff that we spoke with had a good understanding of MCA, how to assess capacity, what to do if someone may not have capacity and best interest decisions. However, four of the staff that we spoke with were unaware of what the MCA was or how it could impact on the people that they were working with.

Care plans showed if people required help with meal preparation when care staff visited. Some people were supported to cook meals and others required prompting to eat regularly. Care plans showed that where they were supported with eating, their likes and dislikes had been documented. People and relatives told us that care workers offered choice and knew what they or their relatives enjoyed eating.

The service did not generally attend healthcare visits with people as these tasks were completed by family members. However, the registered manager told us that care workers would go with people to appointments if it was necessary. Care workers were aware of how to refer people if they thought their health needed attention. We saw emails confirming that where healthcare issues had been identified, people had been referred to other healthcare professionals such as, occupational therapy, district nurses, GP's and physiotherapy. Where the care workers identified that people may need increased time with care visits and if their needs were increasing there was documentation that the service requested increased funding to be able to continue providing care.

Good

Is the service caring?

Our findings

People and relatives were generally positive about the care that they or their relative received. People said, "Oh yes. I've never had anyone boss me around", "Oh yes. They treat me with a great deal of compassion" and "Yes they [care workers] are definitely caring. They speak kindly and nicely". Relatives said, "They don't rush [relative]. His walking is unsteady they walk behind him and encourage him to do better", "They chat happily with [my relative]" and "They know [relative] so well. It's lovely." However, some people told us, "I would say 90% of the time [care workers are caring]. They do always seemed to be rushed and I have to rush with them and I can't do that", "Yes, they seem like they do [treat the person kindly] just really busy and rush in helping me" and "Most of them do [treat the person kindly]. Sometimes you get one or two that aren't interested."

We saw that care plans stated how people wanted their care to be delivered. One person's care plan said, 'I may not be able to understand all that you say but I like to listen and care workers talking to me' and 'Carers to ring the bell first and then let themselves in. The door is never locked.'

People and relatives had differing experiences with regards to having the same care workers visiting them. Some people and relatives said that they had regular carers, However, some relatives told us, "There are a lot of different ones that come around and I don't always know who it is" and, "I see a different one each time I go down there." Care coordinators in the office told us that they tried to ensure that people had carers that they knew but this was not always possible.

We asked people and relatives if they thought the service treated them or their relative with dignity and respect. One relative said, "My mother has been bed bound for five years now and I think they try to create more dignity for her. They also respect her privacy like they will announce they are coming or if she wants privacy when she wants to eat." Care workers told us, "If I go to support people and their children are there, would ask them to excuse us and leave the room [when conducting personal care]. I don't strip them fully. I cover them and I'll do top half first and ensure their bottom half is covered. It is very important to maintain somebody's privacy and dignity."

We asked care workers what they understood about equality and diversity. One care worker said, "Showing respect that we're all different. You may not be aware if someone is gay or whatever but I am there to provide care. You're in their home. The person is the priority." Another care worker said. "I won't feel anything different [about working with people with different faiths or sexuality. I am there to do a job. I treat them the same as anyone I care for. That's their choice. I have to be professional and maintain confidentiality." One relative said, "Yes [care workers show respect] we are Muslim, they respect my house."

The Field Care Supervisors (FCS's) and care workers told us about the importance of treating people with dignity and respect and making sure people were seen as individuals and had their needs met in a person centred way. Care workers understood person centred care and ensuring that people were at the heart of the care that they provided. One care worker told us, "Person centred care is anything that you do must include the service user. You give them a choice, independence and empower them. Don't assume that they

want this." Other care workers that we spoke with told us about the importance of allowing people to do things for themselves where they were able. Care workers said, "Care is about enabling people and maintaining their independence where we can" and "If you read the care plan you get to know their likes and dislikes, difficulties, challenging behaviour." One person's care plan noted, '[Person] wishes to remain as independent as possible with the choices she wants to make in her life'.

During one of our visits to a person's home, we observed a care worker arriving for their shift. The care worker let herself in and a loudly announced that she was there. There was a friendly greeting between the person and the care worker. The care worker had also purchased the person's favourite toiletries on her way to the visit. The person told us, "She [the care worker] is superb. She's my regular and I know her really well. So lovely." The interaction between the care worker and person was warm, friendly and genuine.

Good

Is the service responsive?

Our findings

People and relatives told us, and records showed that people receiving care were involved in planning their care. Where people were unable to be involved there was documentation of family members' involvement in planning care. Relatives said, "Not involved but I do sit in. My mum is able to make her own decisions and they listen, take notes and create a care package", "Yes as her son I do a yearly review with the council and Westminster Homecare is always included" and "They have a yearly review." One relative felt that the service had been responsive to their relatives needs and said, "Recently we had to change the care as I had to go into hospital and we had to add a shopping packing and a cleaning one as I do that both and they revised it for my needs."

A social and life history was documented within each care plan. This was detailed, person centred and asked people about their preferred choice of carer. However, care plans did not always contain information on people's medical history and how their health conditions may affect them. People's diagnoses were listed with no further information. Staff were not always aware of significant information regarding the people that they were caring for and how this could impact on how they provided care to that person.

Care plans were person centred with regards to information on care visits and what care workers needed to do during each visit. There was a list of tasks and in all cases we saw that the care plan noted how people wanted their care to be delivered.

People using the service were provided with information that gave detailed guidance on how to make complaints when they started using the service. Information on how to complain was located in people's care files in their homes. Since January 2016 the service had received 78 complaints. When a complaint was received, records showed that the service wrote to the complainant acknowledging their complaint and provided information on how complaints were dealt with. Following an investigation, the service then wrote to the complainant with the outcome.

A relative told us, "Yes I have had contact with Westminster Homecare on numerous occasions and they have a separate complaint officer. Towards the end of last summer the staff were coming in two hours late. One of the staff went off sick and it took two hours to find someone. Mother called me and I phoned the office and they were quick to solve the problem." Other people and relatives that we spoke with knew how to make a complaint.

Requires Improvement

Is the service well-led?

Our findings

Records showed that the operations manager completed monthly audits of the service. We looked at monthly audits for March, April, May, June and July 2016. However, each month the operations manager only looked at one person's care plan. An audit in April 2016 had identified that the risk assessment had been inadequate and FCS's received training in May 2016 around completing risk assessments. Despite this training, risk assessments were not in place or insufficient to address known risks.

The service had a policy that six monthly audits of MAR charts were to be completed by FCS's. However, medicines audits did not always look at the most recent six months MAR charts for people. One medicine audit completed in January 2016 looked at one month's MAR chart from March 2015. Others only looked at two or three months of MAR charts. Whilst there was system in place to audit MAR charts, this was not consistent and the auditing process failed to identify issues identified on this inspection.

An annual audit had been carried out in July 2015 by the compliance team of Westminster Homecare. The audit identified some, but not all of the issues that we found during the inspection. Whilst medicines audits were completed by FCS's, the registered manager was unaware of the issues that we found on the day of inspection. Care plans were audited and signed off by the deputy manager. However, these had failed to identify the issues we found around people's background histories and lack of risk assessments.

The service had received 78 complaints from January 2016 to date. Many of the complaints that we looked at were around care workers being late for visits. Whilst the complaints had been handled satisfactorily, complaints had not been analysed for trends and the issues around late visits had not been addressed.

The registered manager provided weekly reports to the branches head office which included information on complaints, safeguardings that had been raised as well as risk assessments reviewed and medicines audits. However, despite the registered manager sending the reports to head office, issues identified regarding medicines and risk assessments had not been adequately identified or addressed.

Audits failed to adequately identify the issues found during the inspection and there was a lack of management oversight by the registered manager of the service.

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

We received mixed feedback about the management team. Some staff said that they did not feel supported by the management team and found some of the management team unapproachable. However, other staff said that they felt supported by the management team.

Staff said they often felt pressurised to work weekends as the agency was often short of staff at weekends. They commented they had often worked seven days a week or 14 days without a break. This had not been identified on care worker rotas that we looked at during the inspection. Care workers were not always sure

about management roles and what office staff did.

There were four Field Care Supervisors (FCS) employed and they were supported by senior care workers. The operations manager explained that the service employed one FCS to approximately every 1000 hours of care provided each week. At the time of the inspection, the service provided 2900 hours of care per week to 371 service users across the two boroughs.

The provider operated on on-call system for out of hour's issues that arose. This operated seven days a week between 17:00 and 09:00 and at weekends and was covered by the FCS's. FCS told us that if a care worker called in sick or was unable to cover care calls out of hours, they often needed to complete these care visits themselves if other care workers were unavailable. This meant that FCS's were often on call whilst completing care visits. FCS's told us that they often worked seven days a week without a break to ensure that care visits were covered. This had not been identified as an issue and there were no plans to address this.

Relatives told us that the on call system worked well and said, "Oh yes out of hours and normal one, we can always get hold of them if need be", "They are quite helpful they do phone back" and "Most times get back to you."

The service had recently launched a service user forum. This was a new initiative to get people who used the services together as part of a social event and obtain feedback from people that used the service. A forum had been booked for 15 September 2016 in Waltham Forest. There was evidence of lots of people accepting to attend. The service was planning to extend this to people that used the service in Enfield and were looking for a suitable location to hold the event.

Records showed that staff meetings called 'Care worker forums' were in place and took place approximately every three months. One care worker told us, "These [care worker forums] are held roughly every three months. They [the service] send minutes attached with the payslips. Yes, I do [feel able to raise issues]. I tell my piece of mind. If there is something wrong I will tell them. We talk about our experiences." Meetings included information on new policies and procedures, time sheets, the company social media page, timings of visits and working with behaviour that challenges. However, records did not document issues raised with inspectors at the time of inspection.

The accident and incident records showed that the registered manager used accidents and incidents as an opportunity for learning and to change practice or update people's care needs. Procedures relating to accidents and incidents were clear and available for all staff to read. Staff told us that they knew how to report accidents and incidents.

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 Care visit were often late. Care workers were often booked for back to back visits. people did not always receive care at the times that they were supposed to. Regulation 12(2)(I)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Audits of the service failed to identify issues identified during the inspection. The registered manager did not have adequate oversight of the service. Regulation 17(2)(a)(b)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to service users health and well being were not adequately assessed around high risk medicines and significant, identified health concerns. regulation 12(2)(a)(b) Medicines were not managed or recorded safely. regulation 12(2)(g)

The enforcement action we took:

Warning notice