Westminster Homecare Limited

Westminster Homecare Limited (Enfield/Waltham Forest)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

At the last inspection of this service on 4, 5 and 6 April 2017 we found that some aspects of the management of medicines were not safe and so there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found that the quality assurance systems regarding medicines auditing and the management of staff rotas and late visits were not well managed and so there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Due to the serious nature of the breaches we took enforcement action against the registered provider. Two warning notices were issued, for Regulations 12 and 17. Warning notices give the provider a specific time frame in which to improve in the areas identified at the inspection.

This inspection took place on 1 and 7 September 2017. We undertook this announced focused inspection to check that the most significant breach of legal requirements in relation to Regulations 12 and 17, concerning safe management of medicines, quality assurance of medicines and staff rotas, which had resulted in enforcement action, had been addressed. The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to ensure that the registered manager or someone that could help would be present during the inspection.

Westminster Homecare (Enfield/Waltham Forest) 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. At the time of the inspection, the service was supporting 298 people.

There was a registered manager in post. 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 the time of the inspection the registered manager was not present as they were on leave. The inspection was supported by the deputy manager, deputy director of operations, an operations support manager and a registered manager from another branch.

During this inspection we found that the provider had not adequately addressed these issues and people's medicines were still not safely managed. Information regarding people's medicines was not always consistent and we found omissions in signing Medication Administration Records (MAR). One person that was at risk of malnutrition had not been receiving their nutritional supplements as prescribed.

Medicine audits were not always clear and failed to recognise risks to people that may have missed their medicines. Medicines issues were often picked up months after an error had occurred.

We received feedback that there were still numerous late care visits. There had been some improvement in staff rotas and rotas now noted five to ten minutes' travel time. However, the provider was not ensuring that

staff received sufficient travel time and we received feedback that there were still numerous late care visits.

The local authority for Enfield had placed an embargo on Westminster Homecare (Enfield / Waltham Forrest) following the last inspection to prevent the service taking on any new people. However, this was not in place for Waltham Forest referrals and the service continued to accept new referrals from this borough. We spoke with and wrote to the provider who said that they would place a voluntary restriction on accepting any further referrals from Waltham Forest. This means that the service will not be currently accepting new referrals.

We also wrote to the provider using our powers under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, to ask the provider to send specific information on actions they intend to take to address the concerns raised in this report.

At this inspection, we found breaches of Regulations 12 and 17 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. There were multiple omissions in signing medicine administration records and care plans were not always updated to reflect a change in medicines. Risk assessments for high risk medicines were not always in place. This put people at risk of not being supported to take their medicines as prescribed.

Is the service well-led?

Requires Improvement

The service was not always well-led. Medicines audits did not pick up immediate issues around people's medicines. The auditing process was not always clear. This did not help ensure risks relating to people's medicines support were addressed.

Staff rotas showed that staff received five to ten minutes travel time. However, the provider did not take into account staff methods of transport. Staff rotas were not adequately managed meaning that some people experience late visits.

Feedback from people, relatives and staff said that communication with the office was not always adequate.

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.

We undertook an announced focused inspection of Westminster Homecare (Enfield/Waltham Forest) on 1 and 7 September 2017. This inspection was carried out by one adult social care inspector and a specialist advisor in pharmacy.

The inspection was carried out to check that action had been taken to comply with two warning notices as the service was in breach of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at the previous inspection, specifically regarding the safe management of medicines, medicines audits and staff rotas.

We looked at 10 people's medicines records and care plans including medicines audits, the electronic booking system for care visits and the missed visits log. We spoke with the operations support manager, the deputy director of operations, a registered manager from another branch that was supporting the inspection on the day, the deputy manager, compliance officer, two care co-ordinators and the training officer.

Following the inspection we spoke with six people who used the service, four relatives and 15 care staff.

This report only covers our findings in relation to the key questions of safe and well-led and in particular the

findings following enforcement action. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Westminster Homecare (Enfield/Waltham Forest) on our website at www.cqc.org.uk

Requires Improvement

Is the service safe?

Our findings

At the inspection in August and September 2016 we found multiple issues and concerns around the safe administration of medicines. This included unsigned MAR charts and no risk assessments in place for high risk medicines. The provider was found to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result of these concerns the registered manager and provider was issued with a warning notice requiring them to be compliant in the safe administration of medicines. At our last inspection on 4, 5 and 6 April 2017 we found that the registered manager and provider had not complied with the warning notices regarding the safe management of medicines and so second warning notices were issued. At this inspection we found that the registered manager and provider had still not met the requirements of the warning notices and so were in continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to safe administration of medicines.

Staff had received medicines training which was refreshed each year. Staff that we spoke with confirmed that they had received medicines training and felt that it had been informative enough for them to safely administer people's medicines.

People's medicines were recorded on Medicines Administration Records (MAR) and a blister pack system was used for some people. A blister pack provides people's medicines in a pre-packed plastic pod for each time medicine is required. It is usually provided as a one-month supply. Where people had boxed medicines, these were recorded individually on MAR charts.

For people taking the medicine Warfarin, which is used to thin the blood and is classed as a high risk medicine, we saw comprehensive risk assessments were in place. These risk assessments gave staff detailed information on what side effects could occur and what to do if they saw these side effects. However, for two people receiving other high risk medicines such as medicines used for heart conditions and the prevention of strokes, there were no risk assessments. The provider had not recognised that these were high risk medicines and required a risk assessment to ensure people's safety.

At our last inspection we found that for some people, the list of medicines they were receiving had been noted on the MAR but that care plans had not always been updated to reflect any changes in medicines. At this inspection we found that this issue had not been addressed. For example, one person had medicines in blister packs but the current medicines listed on the blister pack did not match that in their care plan. The care plan had not been updated to include the new medicines that had been prescribed. For another person who had been prescribed new medicines following hospital treatment, their care plan had not been updated to show that new medicines had been prescribed. Another person was receiving a high risk medicine and this was recorded on their warfarin MAR chart for the dosage being 3mg Sunday and 4mg the rest of the week. However the person's medication information in their care plan stated their dose of warfarin as 1mg daily. The lack of consistency could place people at risk of harm because staff had conflicting information.

One person who had been discharged from hospital and was at risk of malnutrition had been prescribed nutritional supplements. The medicines list from the hospital noted that the supplements should be given 'qds' meaning four times a day. This had been transcribed onto the MAR as three times daily. The compliance officer stated that the staff transcribing the list of medicines onto the MAR did not know what this frequency abbreviation meant. The person had not been receiving the correct dosage of nutritional supplement. We saw that persons MAR chart from 6 July to 18 July 2017 which showed the person had been receiving the supplement three times a day. This had not been picked up on by staff and it was unclear if, to the time of the inspection two months later, the person had only been receiving their supplement three times a day which placed them at risk of malnutrition. Following the inspection we contacted the registered manager to ensure that this issue was being followed up. The registered manager contacted the person's GP to ensure that they were receiving the correct amount of nutritional supplements.

One person's daily visit logs for June 2017 showed care staff administered them a prescribed topical cream. However, this had not been included on the person's MAR. The provider's own policy stated, 'The Medication administration record will include the name of the Cream/Lotion.' Staff had not followed the provider's policy and ensured that the cream had been included on the MAR and it was therefore not signed as being administered. Where the topical cream was not on the MAR chart, this means that care staff may not be aware that it would need to be administered and the person may not receive the cream.

There were numerous omissions in signing for medicines on the MAR's that we looked at. There were no records held at the office to adequately document if care staff had raised this issue with the office or if any action had been taken.

The above evidence demonstrates multiple failings around the safe management of medicines, which is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection on 4, 5 and 6 April 2017 we found that medicines audits were not being adequately completed and that whilst medicines audits had identified gaps in the recording of the administration of medicines, they did not always identify the issues we found such as missed medicines and unclear recording. Medicines audits had identified gaps in the recording of the administration of medicines. However, they did not always recognise and identify issues found during the inspection, such as missed medicines and unclear recording. We issued a warning notice regarding this. At this inspection we found that the provider had not adequately addressed this issue and so were in continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to good governance.

The provider's medicines policy stated that there was a two tier auditing process regarding medicines. One was completed in people's homes on a six monthly basis and the other completed in the office when Medicine Administration Records (MAR) were returned to the office. The audit completed in people's homes was brief and covered what medicines people were taking and if the medicines were stored securely. It did not audit MAR charts or check if there were any omissions in staff signing the MAR chart to ensure medicines had been administered. We discussed this with the deputy director of operations who said that the organisational medicines policy stated that the six monthly audits were reviews of people's medicines.

For all people receiving medicines, MAR charts were returned to the office for the second check. However, this may be months after the medicines had been administered or omitted and therefore the time frame for intervention had been lost. For example, one person receiving a high risk medicine to help prevent strokes had missed five doses of their medicine according to the May 2017 MAR, but the audit had been a month later. At the time of the inspection office staff were unable to tell us, and the audit did not identify if the person had received their medicines or if the office had been aware that the medicine had not been administered at the time. One of the office staff told us that staff were supposed to call the office if they noticed any gaps on the MAR but this had not been happening as regularly as it should have been. All staff that we spoke with following the inspection were clear that if they noticed any issues with MAR charts or people's medicines, they were supposed to contact the office.

There was no guidance on how often detailed office audits should occur. Since the last inspection, office staff confirmed that they had received training around the auditing process. Whilst auditing was more detailed than the last inspection there were still issues with regards to how often office audits should be completed.

The provider had recently introduced a form where only medicines in blisters should be listed on the front of the MAR. The MAR that staff signed would then state blister pack and be annotated at what time to be given. We reviewed examples where this was the case. However, in others the medicines were individually documented on the MAR rather than on the front of the MAR and so there was no consistency of approach. The provider's policy stated, 'Medication stored within an MDS (blister pack) must be recorded as individual medication on the administration record sheet to reduce risk and monitor medicines administration'. This meant that, according to the provider's own policy, each medicine should be listed individually on the MAR

chart where staff sign to say that the medicine had been administered. The supporting registered manager confirmed the instruction was contradictory to the system stating that only medicines in blister packs should be listed and made definitive instruction unclear for staff.

For a specific high risk medicine, warfarin which is used to thin the blood, new MAR had been introduced since the last inspection. These MAR only had this specific medicine listed on them. Audits of these charts at office level confirmed they were signed by care staff administering the medicines. For Enfield the branch was sent a copy of the anti-coagulant clinic dosing schedule so the dose signed for could be compared to ensure that people were receiving the correct dose of their warfarin. However, for Waltham Forest the same MAR chart was in place but the service did not receive information from the anti-coagulant clinic regarding people's doses of warfarin. This meant that the audit of warfarin MAR charts for this borough only checked if the person had been administered their medicine but was unable to check that the correct dose had been given.

For one person receiving warfarin, their MAR had not been audited for July 2017 at the time of this September 2017 inspection. The length of time between the MAR being checked and administration limited the provider's ability to respond in a timely manner if the medicine had been incorrectly administered or missed.

Another person's chart was noted to have multiple entries with a red 'o' following an audit. The compliance officer explained that the branch manager had instructed that 'o' be added in the office at the time of audit. The purpose of this was not clear nor was the chart dated or signed. The senior management team at the branch on the day of inspection confirmed that this this was not company policy. It was not clear if any action had taken place to check if the gaps had been missed signatures or missed medicines. This demonstrated ineffective auditing of the person's medicines support.

The above evidence demonstrates a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found significant issues in the way that care staff rotas were set and managed, which did not take into consideration appropriate travel time according to the distances between each care visit allocated. We found that the provider had put five minute travel allocations between care visits. We also found that lateness was an identified issue within the Enfield team and the registered manager also confirmed that the provider was considering a number of monitoring systems with a view to making improvements in this area. Where the service had an active electronic call monitoring system within Waltham Forest, such concerns or issues had not been identified.

At this inspection we found that this issue had not been fully resolved but the provider had taken action to address the issue. The provider still used a five minute travel time for care staff to get to visits. We looked at 35 staff rotas, all of which showed that staff had been allocated five to ten minutes to travel between care visits. We were shown a new alert on the office booking system that would be displayed when care co-coordinators were booking care visits to say how far it was for the care staff to travel to the next visit. However, rota systems were still not effective as they did not take into account if staff drove, walked or used public transport. We raised this with the registered manager that was supporting the inspection from a different branch and the operations support manager. They confirmed that the issue of staff transport was not always taken into account when booking care visits.

The people using the service from Waltham Forrest still had their care visits monitored by an electronic system. This is where care staff log in and out at their visits using a telephone system. If a staff member had

not logged in or out an automatic alert was sent to the office within 30 minutes and office staff would follow this up. If a person was supposed to be receiving medicines at the visit, the alert of a care worker not arriving was sent to the office after 15 minutes. Out of hours, the alert would be sent to the on-call person's mobile telephone. However, in Enfield there was no electronic monitoring system in place and monitoring of late visits relied on people or relatives calling the office. At our last inspection registered manager said that the provider was looking to introduce electronic call monitoring. At this inspection we found that this was not in place. The deputy director of operations confirmed that this was still being looked into.

The deputy director of operations told us, "The manager has to report weekly on missed visits. We review the missed visits and look at any familiar patterns of names and look at performance." In July 2017 there were 14 documented missed visits, one in June 2017 and five in May 2017. All of these had been investigated by the service and actions put in place where necessary to prevent them happening again.

The deputy manager told us that where possible, care visits were booked for staff where people lived in the same area. We were shown an example where one care worker had two visits for people that lived on the same street. However, we received mixed feedback from staff. Some staff told us that they would often have a care visit in one postcode and then have the next visit in another postcode with five minutes' travel time. Staff told us, "We definitely don't get travel time. If you have a client [in one postcode] you could have the next client in [another postcode]. Travel time is very chaotic. It has not got any better", "We don't get enough travel time between clients. We are back to back. I don't think they look at a map. The clients do complain. It's not efficient in the office. We receive our rotas often after 5:00pm so it's difficult to contact them [office] if there is a problem" and "They don't take into account that I walk. I tell them but they don't seem to listen. I don't get five minutes." Another staff member commented, "Now, after the last CQC inspection they put gaps of five minutes. [If travelling to another postcode] it's not enough time."

We found that feedback from staff that drove to care visits was more positive. Staff said, "I'm ok with travel time because I'm a driver, I get five minutes between" and "There has been a change from how it was previously. There is now five minutes between each visit where there wasn't before. That's sufficient time for me. I am now turning up more or less at the scheduled time."

All staff that we spoke with said that they would ring the office if they were running late. However, some staff and people that we spoke with said that this was not then passed onto the person using the service. One staff member said, "You phone the office [to tell them you are running late] and they are supposed to call the service user and they don't. It's a lack of communication." Another staff member said, "I would like my company to run things better. They lack basic communication."

Feedback received from people was also mixed. People told us, "If they're going to be late they call me", "I'm happy with the carers but the office is a mess. They send carers here, there and everywhere" and "They're okay sometimes, sometimes they're late. Sometimes the office call you and sometimes they don't." Other people said, "I am very lucky. My carer that I've got, he is 100 per cent. He gets as near to the time as he possibly can" and "She's always on time." Another person said, "They never tell me if there is a change [of carer] or if they are going to be late." A relative said, "Sometimes they're on time, sometimes they're not. They don't call me and let me know."

Whilst there were some improvements around setting and monitoring rotas and travel time, this had not been fully resolved. Feedback from staff, people and relatives showed that there was inconsistent communication from the office to people that use the service and staff. There were still issues with the provider ensuring adequate travel time between visits to minimise late calls.

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 The provider was failing to ensure the proper and safe management of medicines. 12(1)(2)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had ineffective systems and processes in place to assess, monitor and improve the quality and safety of the services provided with specific reference to auditing of medicines. 17(1)(2)(a)