Westminster Homecare Limited

Westminster Homecare Limited (Wandsworth)

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
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 1 and 5 June 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in. This was the first inspection of the service since it registered with the Care Quality Commission (CQC).

Westminster Homecare Limited (Wandsworth) provides personal care for people in their own homes. At the time of our inspection there were approximately 230 people receiving personal care from the service in the London Borough of Wandsworth and the London Borough of Merton.

There was a registered manager at the service. 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.

People and their relatives told us that they felt safe in the presence of care workers. They told us that staff had a caring attitude, respected their privacy and dignity and they took their preferences into consideration when supporting them with personal care or supporting them to eat and drink.

Risk assessments were completed when people first started to use the service. These included a medicine risk assessment, moving and handling risk assessment and an environmental risk assessment.

Care plans were comprehensive in scope. Care and support plans included people's profile, their care and support plan routine and a social and physical profile. The care and support plan routine included details of tasks to be carried out at each visit and the time and length of the visit. Information in this section was written in plain English, easy to understand and provided care workers with clear steps about the tasks to be competed.

Care and support plans included details of their prescribed medicines and the level of support required. The provider had recently introduced medicine administration record (MAR) charts for care workers to clearly record the medicines that people were being supported with.

Induction for new staff lasted for five days and was based around the Care Certificate. Following the induction training, refresher training was delivered at different intervals in a number of areas relevant to care. The provider used a centralised system to monitor and maintain staff training records which gave up to date information of when training had been completed and when it was due to expire for each care worker.

The provider investigated the complaints received and where appropriate, notified the local authority and completed formal investigation reports. They also took action where needed.

People told us the service was good but that one aspect of the service that could be improved was the

communication from the office team.

Quality assurance audits were in place and were effective in identifying areas of improvement. Actions were identified and assigned to members of the management team to follow up.

During the inspection we reviewed some reports for safeguarding concerns raised at the service, we found that we had not received notifications for all of these in a timely manner, as required by law.

We found a breach of the regulations in relation to notifications. You can see what action we have told the provider to take at the back of the full version of this 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?

Good

The service was safe.

People and their relatives told us they felt safe. Care workers were familiar with safeguarding procedures.

The provider had implemented new medicines administration record (MAR) charts to record when they supported people with their medicines. Care workers were assessed on their competency in medicines administration.

Risk assessments were completed when people first started to use the service and action taken if risks were identified.

Is the service effective?

Good

The service was effective.

Care workers received regular training.

The provider managed people's dietary and healthcare needs.

People told us they were involved in their care and their consent was sought prior to care being delivered.

Is the service caring?

Good

The service was caring.

People praised their care workers for their caring attitude and said they protected their privacy and dignity.

Care workers respected people's choices.

People said that caring relationships had developed with their care workers due to the length of time and regularity with which they received care.

Is the service responsive?

Good

The service was responsive.

Care plans were written up and agreed with people after an assessment of their needs.

Care and support plans included peoples profile, their care and support plan routine and a social and physical profile.

People's care plans were regularly reviewed.

The provider investigated the complaints received and took appropriate action where needed.

Is the service well-led?

Requires Improvement

The service was not well-led in some aspects.

The provider did not always notify the Care Quality Commission (CQC) of certain notifiable incidents.

Care workers told us they felt supported.

The provider completed audits based on the five key questions of the CQC methodology.

Westminster Homecare Limited (Wandsworth)

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 checked 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 this comprehensive inspection on 1 and 5 June 2017. The inspection was announced, the provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in.

The inspection was carried out by two inspectors on the first day and one inspector on the second day. An Expert by Experience spoke with people using the service and their relatives by phone after the inspection.

Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service.

During the inspection we spoke with the registered manager, a care coordinator, a field care supervisor, the staff member responsible for workforce management system and six care workers. We looked at 14 care records, six staff records, training records, complaints and audits related to the management of the service.

After the inspection, we spoke with 20 people using the service and five relatives.

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe in the presence of care workers. Comments included, "Yes I feel safe", "I do feel very safe, I have the same person who comes in", "My [family member] is very compis mentis and would soon say if s/he felt unsafe", "No problems with safety. We have the same carer who comes in and [my family member] trusts them" and "We have just the one carer. [My family member] is very happy and trusts them."

Care workers were familiar with the term safeguarding, what it meant and how they would report any concerns. They said, "Safeguarding is looking after the service users to protect them from abuse. To look after their wellbeing", "If people are not themselves, feeling withdrawn, I will speak to them first and then I can call the office" and "If you have concerns, they (the office) will listen."

The provider kept a safeguarding folder with a record of all their safeguarding allegations that had been raised. These records were completed appropriately and included investigation reports and associated records such as daily logs, medicine administration record (MAR) charts and other documentary evidence needed to complete their investigations. They had also notified the local authority of these.

People told us that in general care workers arrived on time and stayed for the agreed amount of time. Some people said care workers were late but this did not have a negative impact on their care. Comments included, "Sometimes they can be late due to traffic conditions. If there is a change the office will let me know", "Occasionally they can be a little late", "Can be a bit late but that is rare. They clock in and clock out, never rush", "They stay for the allocated time", "They do all I expect, never rushed" and "Usually on time and do all that is expected."

Rotas were sent to care workers on a Wednesday for the following week and an updated rota was sent on Friday to reflect any changes. Care workers clocked in and out using phones in people's homes, manual timesheets were only accepted if people did not consent to the use of their phones. Electronic monitoring was in place to confirm the times that care workers attended to their calls, care workers were paid according to the time they completed.

Care workers told us their rotas worked well for them, "I work in a certain area and all my calls are there, I have enough time to travel between clients" and "If I'm running late, I inform the office."

We asked people if care workers supported them with medicines and if they were happy with the support. They said, "Yes. They always make sure I take it and record it", "Yes, and they check my pack in case I've missed", "No, they do check my blister pack though" and "Yes they do, very happy with the support." Some people told us they managed their own medicines and sometimes the care workers just reminded them.

Care and support plans included details of their prescribed medicines and the level of support required. The provider had recently introduced MAR charts for care workers to clearly record the medicines that people were being supported with. We were unable to check any records as the operations manager said none had

been bought back to the office for audit purposes and were still in people's homes.

Care workers had received training in medicines which included a practical assessment in people's homes carried out by a field care supervisor. A care worker told us, "I assist [person] to take their medicines from the dosset box."

Care workers were aware of the risks to people, one care worker explained that a person they supported was at risks of falls and told us how they supported them. Another said they supported a person with swallowing difficulties and "I was there when the physio was in and told us about the swallowing technique."

Risk assessments were completed when people first started to use the service. These included a medicine risk assessment, moving and handling risk assessment and an environmental risk assessment.

People's medicines support was risk assessed by the provider during their initial assessment. This looked at the dispensing of medicines, medicine support needs, details of the dispensing chemist and the level of risk.

The moving and handling risk assessment assessed people's mobility, their physical wellbeing, any pain and any environmental hazards relating to mobility. Areas of risk were relating to moving and handling were identified, along with the remedial action needed to reduce the risk. Any equipment used for moving and handling tasks were documented included the type of equipment, when it was last serviced and who it was supplied by.

An environmental risk assessment which included the home environment, electrical and gas appliances, fire safety, utilities and waste management was completed during the initial assessment.

Good

Is the service effective?

Our findings

People were supported by care workers who received regular training which helped to meet their needs effectively.

Care workers told us, "Training is good, they look at our roles and tell us what we need to do", "The training was good, if you didn't understand they explained it again" and "I'm going to start supporting someone with a stoma bag so they will put me on training for that."

Induction for new staff lasted for five days and was based around the Care Certificate. The Care Certificate is an identified set of 15 standards that health and social care workers adhere to in their daily working life. It is the minimum standards that should be covered as part of induction training of new care workers and was developed jointly by Skills for Care, Health Education England and Skills for Health.

Following the induction training, refresher training was delivered at different intervals in the following areas: health and safety, fire safety, first aid, pressure ulcer prevention, infection control, the Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS), safeguarding, dementia awareness, medicines, moving and handling and food hygiene. Other specialist training was available as required depending on the individual needs of people using the service, this included stoma care, catheter care, end of life care and how to safely support people with epilepsy.

A dedicated training coordinator oversaw the training of care workers. They told us they ran a monthly refresher training calendar according to the needs of the service which all managers and care coordinators received a copy of to allow them sufficient time to book in staff.

There was a training room available in the main office containing equipment for care workers to practice on and familiarise themselves with. There were also posters about pressure sores, MCA/DoLS, whistleblowing and safeguarding on display.

The provider used a centralised system to monitor and maintain staff training records which gave up to date information of when training had been completed and when it was due to expire for each care worker. All training was recorded within this system which was also used for the completion of the training attendance register and issuing training certificates. The operations manager showed us a list of care worker training that was due to expire which demonstrated that care workers were up to date with their training and training that was due to expire had been identified and booked in.

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The provider's policy stated that 'All six week supervision meetings for newly appointed employees must be confirmed and verified. To further monitor and mentor newly appointed employees as part of the individual's 12 week supervision programme, following a six week supervision the employee's final one to one meeting, under the initial 12 week communication programme, is to be conducted a further six weeks following their previous one-one supervision.'

We saw that some carer workers that had started did not receive a six or 12 week supervision as stipulated in the provider's policy. We highlighted this to the operations manager who told us they were in the process of rolling these out to new starters.

There was evidence that care workers were supervised through one to one supervisions and spot checks.

People and their relatives told us they were happy with support they received with their meals which mainly consisted of preparing food that was already available in people's homes or heating up ready meals. They said, "They will do a bit of shopping and get my meals. I have ready meals, they will put a jacket in the microwave", "They just need heating mostly, they do cook occasionally", "They do a microwave meal for me in the evenings", "My [family member] and I take care of meals", "Yes they prepare ready meals for him/her and [my family member] eat" and "Mostly microwave meals."

Care workers that we spoke with were familiar with people's preferences in relation to their dietary needs. This corresponded to what had been documented in the dietary needs section of their care plans. Comments included, "[Person] gets meals on wheels and I offer them a choice", "[Person] likes cereal and toast for breakfast", "[Person] likes ice-coffee in the morning, they like cold porridge as well so I make that before I start the personal care" and "[Person] likes hot Ribena." Another said "[Person] orders meals from a company" and "He/she likes biscuits and chocolates, he/she prefers diluted drinks." We checked what care workers told us with regards to people's preferences against what was written in their care plans.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack 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.

Care workers were familiar with the MCA and its implications for people using the service. They told us, "The MCA is used to protect people who lack capacity. You cannot assume they can't make decisions. Sometimes you have to give them more information so they can make a decision", "Even if decisions are unwise, you have to respect them", "[Person] has dementia but has the capacity to understand" and "If people refuse personal care I would try and persuade them and if it carries on then inform the office as it could be neglect."

People told us they were involved in planning their care. Comments included, "They come in once a year to see if things have changed", "My care has been put together by Chelsea & Westminster, I have a copy (of my care plan)", "My [family member] and doctor helped put the plan together. Yes they took my preferences into consideration", "Wandsworth put it together and I have a copy", "Yes it (my care) is reviewed regularly" and "It was initially put together with the agency and hospital, we have a copy."

Care and support plans included 'service users' agreements' detailing frequency and type of service that had been agreed, these were signed by people using the service indicating their consent. They also included a section called 'consent to my care and support', the provider recorded people's consent for the provider to carry out assessments and access to records. People had signed their care and support plans to indicate their consent. Where people were unable to give their consent, their representatives or health professionals that had been involved had signed the forms on their behalf.

People told us that care workers looked out for their general health. Care and support plans included

people's current and past medical history and their prescribed medicines. Their prescribed medication was included, even if they were not being supported in this regard so that the care workers could have access to this information should the need arise.

A range of factsheets related to common health conditions were included in care plans, for example Urinary Tract Infection (UTI), falls, diabetes and actions to take in the event of emergencies, for care workers to refer to if needed.

Good

Is the service caring?

Our findings

We received positive feedback from people and their relatives about the attitude of care workers towards them. They also told us that care workers were kind and caring. Comments included, "Very kind and polite", "The carer is lovely, always on time, and kind and caring", "They are kind and helpful", "I've had a few bad ones in the past. It's alright now", "I can't fault the staff. They are kind and caring", "I would call them angels of mercy. They are very good at what they do", "Delivers excellent care in a very respectful way", "They are very thoughtful" and "Very kind, exceptional."

People said their privacy and dignity was respected, "They respect my privacy and dignity. I live alone so when they help me wash there isn't a problem", "They never discuss other people", "They are respectful and always knock if I'm in the bathroom", "They respect the fact that I like to shower myself but there are some parts I can't reach, they will wait for me to call them before they come into the bathroom", "They are respectful and polite, never discuss other service users and never embarrass me", "[The care worker] will wait outside my room whilst I dress but will come in if I call", "I don't feel uncomfortable with them", "They keep the bathroom door shut even though there is just us", "They are very protective of his/her privacy and dignity" and "I trust them to respect my privacy."

Care workers told us ways in which they protected people's privacy and dignity, "When I do personal care, I ensure windows are closed and cover the half not being washed" and "I do everything under a blanket."

Care workers respected people's choices. People and their relatives said, "They do what I ask", "They ask what I would like to eat", "They always ask what I need and take note" and "They listen to him/her and respect his/her decisions."

Care workers told us, "I give [person] a choice, ask (them) what they would like to eat", "In the care plan, they always put the preferences in but I always offer a choice", "I approach each client differently, they all have different needs", "[Person using the service] has a visual impairment so I make sure I introduce myself" and "I help [person] to strip wash, but they choose what they want and lead the way."

Some people said that caring relationships had developed with their care workers due to the length of time and regularity with which they received care. They said, "Yes, it's a very good service. I have two regular carers", "Yes more or less, I have the same people. I'm quite happy", "I have three or four regular carers", "I have had the same person for some time, you get to know them", "Yes I'm happy I have the same carer", "We have regular staff, they are excellent", "[The care worker] is a pleasure, part of the furniture and a good friend" and "I have three regular people, they have become good friends."

Care and support plans included people's profile and social history. Profiles included details of their next of kin and important people such as their GP or other health professionals. Their social history contained details about the person and their life history, and also included their likes and dislikes in relation to the support provided and their preferences for a male or female care worker.

Good

Is the service responsive?

Our findings

People's needs were assessed prior to the commencement of their care. The field care supervisor was responsible for carrying out assessments.

We spoke with a field care supervisor who was responsible for assessing new people and also carrying out reviews, spot checks and medicines competency assessments.

They spoke to us about the process of accepting new referrals which would usually come to the care coordinators first to check if they had capacity to support people. They told us they received assessments and care plans from the local authority but carried out their own assessments. The field care supervisor met with people to gather a better understanding of their needs and carry out a risk assessment and support plan which would be typed up and a copy left with the person using the service.

Care and support plans included people's profile, their care and support plan routine and a social and physical profile.

The care and support plan routine included details of tasks to be carried out at each visit, and the time and length of the visit. Information in this section was written in plain English, easy to understand and provided care workers with clear steps about the tasks to be competed. A care worker said, "The care plans are easy to understand, if you notice any changes they will update them."

The social and physical profile contained person centred information in relation to number of areas including how people communicated, their emotional wellbeing, sleep routine, dietary needs and personal hygiene. Each area included people's level of independence, and how they could be supported in that regard.

Some aspects of the social wellbeing section were not completed appropriately. For example, in one care plan it said "I socialise well but I have no family/friends. Sometimes I am not motivated because of loneliness." There was no further information about how care workers could support this person in this aspect. Another person had been seen by the psychiatric team due to depression, but the action for staff was 'supervision' of this person without any further details about the type of support that could be provided. We highlighted these to the operations manager during the inspection who agreed to put further guidance for staff in place as soon as possible.

People's care plans were regularly reviewed. Comments included, "Yes, often due to changes in my health", "Yes, just a short time ago. They did ask my thoughts on the service", "It has been reviewed at least twice", "They came in recently", "It was looked at two months ago, someone from the office came in", "Yes, once a year. [My family member] had a review recently" and "[My family member] has had a review every year."

The field care supervisor told us that a home visit quality monitoring check would be carried out every six months and a full assessment annually. Other checks included direct observations/spot checks and

telephone monitoring.

Home visits reports were quality monitored and also a log book audit was conducted. The log book audits typically covered a month period and looked at whether there were any gaps in any of the records or information was not comprehensive. We saw examples where the provider had taken action such as holding one to one supervision with individual members of staff where areas of improvement were found.

In the records we saw, the daily logs were completed well with details of the personal care tasks assisted with, what people ate and how they were feeling. Other details such as any health professionals contacted were also completed.

Additional records such as food and fluid charts were available if they needed to be completed to support people with their nutrition and hydration.

People and their relatives said if they had any concerns they were able to raise this with the provider and felt that they would be listened to. They said, "I can talk to the office, they do listen", "Yes, they always listen" and "In the past I have when carers hadn't turned up. Yes they listen."

We reviewed the complaints since January 2017, there had been 10 recorded complaints, five of these were missed or late visits. The provider investigated the complaints received and where appropriate, notified the local authority and completed formal investigation reports. They also took action where needed for example, increased monitoring for care workers and calling them in for a one to one supervision.

Requires Improvement

Is the service well-led?

Our findings

The provider did not notify the Care Quality Commission (CQC) of certain notifiable incidents. There was inconsistency with the provider's procedures with regards to submitting notifications. At the time of the inspection, CQC had only received two notifications, whereas the information that had come from the local authority showed there had been other safeguarding concerns that we had not been notified about.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People told us the service was good, "It is good for me", "Very good", "It's a very good service", "We are quite happy", "Yes it is a good service", "It's a reasonably good service", "It's pretty good", "Quite happy", "I'm very happy", "I have no complaints" and "They do a good job."

Some people said that one aspect of the service that could be improved was the communication from the office team, "Communication when a regular worker goes on holiday", "Just communication with the office (could be better)", "Communication is the biggest bugbear" and "You can speak to them but communication is not one of their skills."

The operations manager was the current registered manager, however the branch manager was in the process of applying to become the registered manager. The office based staff were divided into two teams overseeing the London Borough of Wandsworth and the London Borough of Merton contracts. There were two care coordinators and one field care supervisor for Wandsworth and one care coordinator and one field care supervisor for Merton. One member of staff oversaw the timesheets and staff monitoring on the workforce management system for both of the teams.

Care workers told us they felt supported, "Their approach has been different (to previous employers), they listen." "I have a good relationship with the office, can always rely on them" and "There is always someone on call out of hours., they are good and will call you back."

There had been one recorded incident where a person using the service had a fall. We saw that the incident log had been completed by the branch manager and signed off by the registered manager.

An internal audit completed in April 2017 was based on the five key questions of the CQC methodology. This was comprehensive in scope and there was a detailed approach to working in line with CQC methodology in order to improve the quality of care and support for people under each question. For example, under 'safe' medicines audits were done, six care workers files audited, daily record sheets and training. Six service user files were looked at under responsive. This audit was effective in picking up concerns, there was an audit overview which identified areas of improvement such as training, medicine administration records (MAR) charts, daily records and care worker files supervisions.

Care worker performance reviews and contract monitoring reviews that we saw showed an improvement in care workers using the clocking in system properly and an increase from 56% to 90% compliance.

The most recent service users survey was carried out in 2015, the operations manager told us this was due to be repeated soon.

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 18 Registration Regulations 2009 Notifications of other incidents The registered person did notify the Commission without delay of some incidents related to abuse or allegation of abuse in relation to a service user; whilst services were being provided in the carrying on of a regulated activity. Regulation 18 (1) (2) (e)