

Westminster Homecare Limited

Westminster Homecare Limited (Norwich)

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This announced inspection took place on 9 and 13 February 2017. Westminster Homecare Limited (Norwich) provides support to people in their own homes. It does not provide nursing care. At the time of our inspection the service was supporting approximately 150 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 this inspection we identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We identified a breach of Regulation 12 because risks were not always adequately assessed and actions were not always taken to mitigate the risks to people. Concerns for people's safety were not sufficiently analysed to help identify patterns of concern. The service had not always ensured they had current and up to date information regarding staff they employed. Medicines were not always safely managed or always given as the prescriber intended.

We found the service was also in breach of Regulation 17. This was because the provider's quality assurance systems had failed to identify the improvements needed. Recording regarding people's care needs and how the service had taken action in response to concerns was poor. People's care records did not always contain sufficient guidance and information for staff.

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. People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. Not all staff understood what the MCA was and how this impacted on their practice. We found the provider was in breach of Regulation 11 as the service was not consistently working within the requirements of the act. This was because mental capacity assessments were not carried out to determine if people were able to make decisions, and if not, a best interests process was not always followed.

Staff spoke positively regarding their training, however we found training was not always provided that was specific to staff role or people's specific needs and health conditions. New staff were provided with a comprehensive induction and the service carried out checks to ensure they were confident and able to carry out their role.

The service liaised with health care professionals to support people's health care needs, where required. However, it was not always clear if this was always done appropriately or when required.

The majority of people received support from regular and consistent staff. This helped staff to provide support in accordance with people's needs and preferences. However, we found some examples where this

was not always the case and people did not always receive support that met their individual needs or preferences.

People told us they knew how to complain and raise concerns. Some of the people we spoke with told us they did not always receive an apology or a clear response to the issues they raised. Formal complaints were investigated and responded to, however where issues were raised in a less formal manner they were not always responded to.

There was mixed feedback from staff regarding the support and leadership of the service. Some staff felt adequately supported by the service managers and administrative staff whilst others did not feel management were always approachable. We also received conflicting feedback from staff regarding morale in the service.

People were supported by caring staff who treated them respectfully and with dignity. Staff supported people to be as independent as possible and consulted them regarding the support provided.

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 consistently safe.

Risks to people were not always sufficiently assessed and actions were not always taken to mitigate risks to people.

Medicines were not always managed safely or given as the prescriber intended.

Staffing levels in the service were adequate.

Is the service effective?

Requires Improvement ●

The service was not consistently effective.

The service was not always working within the requirements of the MCA.

Staff spoke positively of their training, however training was not always provided that was role specific or specific to people's individual needs and health conditions.

The service liaised with health and social care professionals but this was not always done appropriately.

Is the service caring?

Good ●

The service was caring.

People were supported by caring staff who knew them well.

Staff respected and promoted people's dignity and independence.

Is the service responsive?

Requires Improvement ●

The service was not consistently responsive.

Care records did not always provide sufficient information or guidance for staff.

Most people received support that met their individual needs

and preferences.

The service investigated and responded to informal complaints. However, people told us that informal concerns or issues raised were not always adequately addressed.

<p>Is the service well-led?</p> <p>The service was not consistently well led.</p> <p>The systems in place had not always been effective at identifying areas of concern.</p> <p>People's care needs and the actions taken in response to concerns were not always recorded.</p> <p>There was mixed feedback regarding communication in the service and the management and leadership.</p>	<p>Requires Improvement ●</p>
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Westminster Homecare Limited (Norwich)

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

This announced inspection took place on 9 and 13 February 2017. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available to respond to our queries.

The inspection team consisted of two inspectors and two experts by experience, who carried out phone calls to people using the service. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before we carried out the inspection we reviewed the information we held about the service. This included statutory notifications that the provider had sent us. A statutory notification contains information about significant events that affect people's safety, which the provider is required to send to us by law. We also spoke with the local authority for their views on the service.

During our inspection we spoke with eighteen people using the service and two relatives via the telephone. We also spoke with six members of care staff, the registered manager, a care co-ordinator, a field supervisor, and the training co-ordinator. Five of the care staff we spoke with over the telephone and the remainder of staff we spoke with when we visited the service's office. We visited the office on two days. At the office we looked at ten people's care records, the medicines records for eight people, six staff recruitment files and staff training records. We looked at quality monitoring documents, accident and incident records, complaints, and other records relating to the management of the service.

Is the service safe?

Our findings

Risks to people were not always managed sufficiently. Whilst risk assessments were in place for people using the service they did not always provide sufficient guidance for staff in managing the risk and not all risks had been identified. For example, we looked at the care records for three people who experienced seizures. We found there was a lack of detailed information regarding possible triggers for seizures or what to do if the person had a seizure. For another person we saw their social work assessment showed they had a history of self-neglect. The service's own assessments had not reflected this as a risk to the person's welfare or planned their care and support accordingly.

We found that risk assessments were not reviewed sufficiently when the level of risk changed. For example, we found one person had developed a skin condition due to the fragility of their skin; however their risk assessment had not been updated to take this condition into account. The lack of adequate guidance for managing risks to people meant the service had not taken sufficient action to mitigate the risks to people using the service.

We saw staff reported concerns regarding people to staff in the office and these were recorded on separate forms. These were then kept separately in each person's care record. It was not always clear how these concerns were responded to and what action staff had taken in response to any risks. The registered manager told us they monitored the information that came in to the office however there was no formal analysis or overview of the concerns that were reported. This meant it would be difficult for the registered manager to identify any patterns or escalating needs so that appropriate action could be taken in response to this.

Medicines were not always managed safely. We looked at eight people's medicines administration records and found medicines had not always been given as the prescriber intended. One person had missed a dose of their pain relief medicine as the timing of visits had not allowed a sufficient enough gap to ensure that it was safe for the person to take the second dose. This meant that they were at risk of not receiving relief for their pain. A second person had been assessed as not being able to manage their medicines themselves. We saw staff had not been able to administer a medicine on two occasions because the person had run out of this. There was no record of what action had been taken in response to this. We saw this person had also been prescribed an 'as required medicine' which had been given on a regular and consistent basis since October 2016. There was no evidence to show that the service had considered if this medicine should be prescribed or given on a regular basis and that this had been discussed with the person and their doctor.

We found staff had not always completed and signed people's medicine records to show medicines had been given as prescribed. For three people we saw staff had indicated that the medicine had not been given, however there was no recorded explanation of why this was or what action had been taken to assess the risk this might pose to the person. We found that there was insufficient detail in people's care plans on how 'as required' medicines should be prescribed. This meant we were not assured that these risks were being sufficiently managed.

Whilst staff files showed that the required character and criminal record checks were carried out, we saw the service did not always have references from the staff members' most recent employer. For example, in one instance the service had requested a reference from an employer a member of staff had worked with two years prior rather than their most recent employer. This meant the service had not taken sufficient action to mitigate this risk as the service did not have the most recent and relevant information.

The above information meant the service was not always taking sufficient action to assess and mitigate risks to people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they felt safe using the service. One person told us, "Yes [staff] are very nice, they are very good with my care and yes, I feel very safe with them." Another person said, "The help from Westminster staff is done safely." A third person told us, "I do trust [staff member] and feel safe and relaxed with the staff here."

The staff we spoke with demonstrated an understanding of how to manage some risks to people. They were able to tell us how they would respond to someone who had experienced a fall and how to manage the risks to people's skin condition. The staff we spoke with were also clear regarding appropriate moving and handling. One staff member told us, "I wouldn't put myself or the person at risk." Another staff member provided us with a good example of how they supported one person who sometimes displayed behaviour that challenged themselves and others.

The staff we spoke with were able to tell us how they would identify possible safeguarding concerns. One member of staff told us how they would identify changes in behaviour and what they would do in response to this. Two other staff members provided us with examples of different types of safeguarding concerns and how they might identify each concern. Staff knew how to report concerns. However, there had been one occasion where the service had failed to follow up a safeguarding concern in a timely manner which had impacted on the ability of the service and local authority to investigate and take action. We were also concerned that although this concern related to an allegation of verbal abuse it had not been identified as a specific safeguarding concern.

People told us they were happy with staffing levels in the service and the majority of people we spoke with did not receive late or missed visits. One person told us, "Yes, they are usually on time. If they are late they let me know." A second person said, "My care is good. Reliable." A third person told us, "They're usually on time but they may be a bit late due to emergencies but it's not often and they let me know. I've not been let down completely." However, one person said, "[Name] was really late one day last week I began to worry how I would manage but [staff] rang from the office and told me they were on their way and would be here very soon I was relieved." Four of the people we spoke with also told us how staff had enough time to support them and this meant they never felt rushed. One said, "Of course we do everything at my pace I am never rushed even though we have a lot to do in the half hour." Another person told us, "They take time to provide the care, to do it properly."

Staff we spoke with told us they got the rosters in advance and with enough time. Staff told us they felt they had enough time to support people. One staff member told us if they reported to the office staff that they felt they required more time to support people this would be taken in to account. Another staff member told us how staff supported each other and helped provide cover to ensure calls did not get missed.

Is the service effective?

Our findings

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

We found the service was not always working consistently within the requirements of the MCA. For example, we found that some people had their medicines locked away so they could not access them. This was because the service felt that people did not have the capacity to manage their medicines safely. We discussed this with the registered manager who told us they would consult with other relevant people such as the local authority and the person's doctor regarding this. However, they could not demonstrate that this had been done. Mental capacity assessments had not been undertaken to determine whether people could consent to this, and there was no evidence, if the person lacked capacity, of how the decision had been made in their best interests. For another person we saw that their care plan stated they did not understand their medicines and how to take them. We saw this person often refused their medicines. The registered manager told us this would be discussed with the person's doctor. However, there was no record that a capacity assessment had taken place to determine if the person had the mental capacity to make the decision about taking their medicines, and if not, what actions should be taken in their best interests. We saw one person's relative was signing on behalf of the person, however it was not clear if the relative had the legal authority to do so and that this had not been checked by the service.

Not all the staff we spoke with knew what the MCA was and how it might impact on how they supported people. This meant that the provider could not be sure that staff were working within the requirements of the act.

The above information meant the provider was not consistently following requirements set out under the MCA. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always receive formal training to support them in their role or help ensure effective care was provided. For example, we saw that the service supported a number of people who experienced seizures. We saw there was no specific training for staff in this condition. We found that some care plans and assessments were not of good quality. The staff that worked in the office told us they did not receive any additional formal training in relation to their role, for example in assessing people's care needs and writing care plans. They told us that staff that previously carried out this role passed on their skills and knowledge. This meant there was a danger that inconsistent or incorrect practice could be shared and poor practice may not always have been identified.

People told us they felt staff were competent and provided effective care. One person said, "Yes, they are trained ok." Another person told us, "[Staff] are doing a good job, I trust [main carer] and they know what to do."

Staff spoke positively of the training they received. One member of staff told us, "Training has always been very good." A second member of staff said, "The training I've had has been useful." Another member of staff told us how the training co-ordinator was approachable and supportive. They told us the training co-ordinator would visit people with staff members and provide additional training if there was anything they were not sure about. Staff told us they had regular training to ensure their knowledge was current and acted as a 'refresher'. One member of staff told us this was, "Very helpful."

We saw the service carried out regular spot checks when staff were supporting people, to help ensure that staff were following their training and providing effective care. New staff received an induction, this consisted of a week of classroom based training, shadowing experienced staff on care visits and competency checks to ensure new staff were competent to start working in the service.

Where people were supported with meals they told us this was done well, with food well prepared, nicely presented and that staff left the kitchen clean afterwards. People we spoke with told us that staff always ensured they were left with drinks so they could remain sufficiently hydrated. One member of staff told us how they provided support to a person with diabetes. They told us they knew about this condition from personal experience which helped them to provide advice and support to the person.

Whilst we saw some good examples of staff reporting and working with health care professionals to support people's health needs, we were concerned that practice in this area wasn't consistent. For example, one member of staff told us they had arrived to support someone and found that the office had arranged for an occupational therapist (OT) to be present at the same time. They said this had been arranged so staff could discuss with the OT the problems the person had been having and provide advice to staff. However, the member of staff told us they had not been made aware that the OT was visiting or what concerns they needed to discuss. This meant they had been unable to provide the OT with the information they needed.

Is the service caring?

Our findings

People and relatives we spoke with talked positively about the staff and their relationships with them. One person said, "Happy with them, they are pleasant, and they will have a chat." Another person told us, "The carers are fantastic. I have a regular lady and she is a joy to have calling." A third person said, "Sometimes I feel a bit low as I don't really have many people come in my house so the carers can really cheer me up by just talking to me we always have a laugh and a joke."

Staff we spoke with told us about the importance of a friendly smile and an open approach. One said, "Hopefully we cheer their mornings up." Two staff told us how they viewed the people they supported like family members. One said, "You do get a bond with [people using the service]."

People told us they were supported the majority of the time by consistent staff who knew them well. One person told us, "I have one main carer now most of the time now and [name] is really good, exceptional. [Name's] now like a friend or family member." A second person said, "They [staff] are nice people and we chat and I see their family pictures and I know them now. It's not strangers turning up." A third person said, "I trust [main carer] and they know what to do. I get the same person every time. And I had a good one before that." Staff we spoke with confirmed that they felt they knew the people they supported and demonstrated this through our conversations with them.

People were involved and consulted regarding their care needs. One person told us, "I say what I want and they respect this." Another person said, "They check things with me." Staff we spoke with understood the importance of involving people in decisions about their care. One staff member said, "I will always ask what they [people using the service] would like because they know what they want at that time." Another staff member told us, "I'd never choose for them [people using the service] because that's not fair." We saw the service contacted people regularly to review and discuss their care needs, people we spoke with confirmed this.

The people and relatives we spoke with told us staff were respectful and treated them with dignity. One person said, "Yes, they are all polite and respectful." Another person told us, "The help they give me is done with dignity and safely." A third person said, "I'm very relaxed with them here and they are polite and respectful in the house. They respect our privacy. They take time to provide the care to do it properly." A fourth person told us, "Yes I couldn't be treated with more respect by any one, some of the girls are like family I couldn't manage without them in my life they are brilliant." When we talked with staff they referred to people in a thoughtful and respectful manner. Staff provided us with examples of practical things they did to ensure people felt respected and their dignity was protected.

Staff we spoke with demonstrated they understood the importance of supporting people to be as independent as possible. One member of staff gave us an example of how they had supported and encouraged a person to regain some independence with their mobility. Another member of staff told us how they would encourage people to help with care tasks; they told us this was important for people so, "They don't feel we're not giving them a chance." A person told us, "The carers respect my independence and

check things with me."

Is the service responsive?

Our findings

The care plans we looked at did not always contain sufficient guidance and information for staff. For example, one person was diabetic and staff supported them with their meals. There was no further guidance or information for staff regarding the management of the person's diabetes in relation to their meals. The care plans were in a questionnaire style format and staff could tick yes or no to questions. However, we found occasions when staff completed yes to indicate the person had needs in this area but did not provide any further specific detail about how staff could support the person. We found this confusing in some areas. This was because ticks had been given to questions where further information was required in order to understand what the tick fully indicated. It also meant the care plans did not have further written guidance to meet people's needs.

Most people we spoke with told us that the care provided was responsive and met their personal preferences. This included visit times, gender of staff, and regular staff. However, three people and a relative told us that they did not always receive support that met their personal preferences. One person said, "Some times have changed without telling me. They are not good at communications. The first time I saw [staff member] they just turned up." A second person said, "They change the times and they even send me a different carer. Yes, we do get a rota but I can't rely on it, it's not right." Another person told us, "I never really know who is coming on what day I don't really mind but it would be better if I did know who was coming as everyone works differently." A relative said, "We've had to chase them about getting the right staff here some of the time in the last year." A member of staff also provided us with examples of occasions when a person had requested personal care be provided by a staff member of the same gender and this had not always been provided.

We saw one person had a care plan in place that detailed they could become anxious if their routines changed or if they were supported by care staff they didn't know. We spoke with this person who told us, "I often wonder what it is or who may call, and it makes me anxious. I could really do without the uncertainty." This meant we were not confident that the service was being provided in a manner that took into account this person's specific needs and concerns.

All staff, apart from one, that we spoke with told us they supported people they knew and were familiar with. This helped them to ensure the support provided met people's individual needs and preferences. From talking to staff it was clear they knew people's individual wishes and needs well and supported people accordingly.

People and their relatives told us that prior to receiving a service staff visited them to discuss their care needs and how best to support them. One person told us, "They did come out first thing to discuss it and I was agreeable to the times and they fit these in. They stick to the plan." Another person said, "I've had the care from Westminster for about 18 months. They went through the care plan with me." People also told us that their care plan and needs were reviewed and discussed, although not everyone could confirm that this was done on a regular basis. One person said, "Yes, I've had reviews with them and they come out here every now and again and they do telephone calls as well and do a survey." Records we looked at confirmed that

people's care plans were regularly discussed with them. This helped to ensure the care provided meets people's needs and wishes.

People we spoke with told us they knew how to complain and raise concerns. One person told us, "Yes I do know how to complain and I certainly would complain if I needed to but they are very good and I am looked after very well." A second person said, "If we have any problems we ring [name] at the office and they help." However, two people we spoke with told us that they were not always happy with the response they received from the office when they raised concerns. One person told us when they had raised a concern they had not received an apology or explanation. The second person told us whilst the service had taken action to address a concern they raised they had not felt that they had received a genuine apology. The registered manager told us that they had identified that issues or concerns told to staff in the office were not always being passed on to them. This meant they were not always able to fully respond to people. They told us they were taking action to address this.

We reviewed the complaints records and saw the service had investigated and responded to complaints received. However, where people had raised concerns or issues in their regular reviews, these had not been formally logged. There was no record of what action had been taken to respond to and address any issues raised.

Is the service well-led?

Our findings

There were systems in place to audit and monitor the quality of the care provided. Office staff carried out audits on medicines and care records, this included looking at care plans and daily logs. Office staff also completed quality monitoring telephone calls and home visits. The registered manager also monitored and submitted regular data on areas such as missed calls, staffing, reviews, and complaints. In addition we saw the provider carried out their own audit of the service, this covered areas such as care plans, staff training, recruitment, and the service's own audits.

Whilst quality assurance systems were in place we found they were not always effective and did not identify all the issues found at this inspection. For example, the specific issues we identified regarding the management of medicines and risk assessments had not been identified. Where issues were noted as part of the auditing systems, the actions taken to address the issues were not detailed. Consequently, the provider could not demonstrate that they had taken appropriate steps to address areas of poor quality or concerns.

We found there was a lack of recording regarding people's care needs and how they were responded to. Care plans did not always provide sufficient detail regarding people's needs or the risks posed to them. The care plan audits in place did not identify issues with the quality or content of care plans. We also found that records in the office did not always provide a full and detailed record of how issues regarding people's care had been addressed or responded to. For example, where a member of care staff had contacted the office to raise concerns about a person's wellbeing there was often no further record of what action had been taken in response to this. This meant the service had not ensured there was an accurate, complete, and contemporaneous record in respect to people's care.

The above information meant the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The feedback we received from people was mixed regarding the communication from the service. One person said, "Have no problem with the staff in the office whenever I need to talk to them they always give me all the time I need to sort anything out." However, two people told us communication could be improved. One person said, "I would recommend the care, not the communication." Another person told us, "I can't usually get through to the office they are very busy you know, sometimes they ring me back but not always if that happens."

We saw the service had introduced a 'service user forum' so people receiving support from the service could attend to discuss and hear about changes to the service. The registered manager told us that this had not been well attended. They told us they had reviewed how they could ensure people were kept informed about the service and were in the process of introducing a newsletter rather than regular meetings. We saw a copy of the first newsletter that was due to be sent out at the time of our inspection. We saw this introduced the office staff and asked people to nominate staff for 'carer of the month' as well as asking people for ideas on items to be covered in future newsletters.

Staff gave mixed feedback regarding the support and leadership of the service. Three staff told us they found the office management team approachable and supportive. One member of staff said, "[Registered manager] tries to sort things out." However, another member of staff told us that whilst they felt supported by some office staff they found the registered manager was not always approachable and supportive. A second staff member said, "If you ask [registered manager] a question they snap at you."

We found at times there was a disconnect between office staff and staff visiting people in their own homes. For example, office staff spoke of good morale in the service. However, this was not always reflected on speaking to care staff providing care visits. One member of staff told us, "The atmosphere [in the office] is horrible there." Another staff member said, "Sometimes you go in to the office and don't get a hello." They went on to say, "Sometimes there is an atmosphere in there and you don't know who to speak to." When we spoke to office staff they told us some care staff did not communicate as required which meant they did not always know if there were issues with the service being provided to people. However, some of the care staff we spoke with told us that office staff did not communicate changes to them or pass on information to people receiving a service. Whilst staff working in the office had regular meetings in which the service was discussed there had not been recent meetings for staff working in people's homes. Care staff we spoke with could not confirm they attended meetings, although some told us they recalled meetings being held in the past. However, we saw the service did send out memos and reminders to staff regarding their responsibilities or changes in procedures.

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	<p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>The provider did not act in accordance with the requirements of the Mental Capacity Act 2005. Regulation 11 (1)(2)(3)</p>
Regulated activity	Regulation
Personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider had not taken sufficient action to assess and mitigate the risks to people. Regulation 12 (1) (2)(a)(b)(g)</p>
Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider had failed to implement effective systems to assess, monitor and improve the quality and safety of the service. The provider had failed to implement effective systems to assess, monitor and mitigate the risks to people using the service. The provider had failed to ensure there was an accurate, complete, and contemporaneous record in respect to people's care. Regulation 17 (1) (2)(a)(b)(c)</p>