Westminster Homecare Limited

Westminster Homecare Limited (Enfield/Waltham Forest)

Inspection report

Refuge House
9-10 River Front
Enfield
Middlesex
EN1 3SZ

Tel: 02082166300

Date of inspection visit:
04 April 2017
05 April 2017
06 April 2017

Date of publication:
21 June 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 4, 5 and 6 April 2017 and announced. We gave the provider 48 hours' notice that we would be visiting their main office so that someone would be available to support us with the inspection process.

We last inspected the service on 30, 31 August 2016 and 01, 05 and 09 September 2016 and found the service to be in breach of Regulations 12 and 17 of the Health and Social Care Act 2008. Issues we found related to unsafe medicines management, lack of risk assessments especially in relation to high risk medicines, poor timekeeping resulting in people not receiving care at their preferred time and poor governance which did not identify the issues that we found during the inspection. As a result of the issues we found, the Care Quality Commission took enforcement action against the provider and issued a warning notice on 5 October 2016 requiring the provider to immediately address the concerns around Regulation 12 of the Health and Social Care Act 2008.

At this inspection we found that although some improvements had been made in response to the warning notice around risk assessments, the provider had failed to make adequate improvements to ensure safe medicines management and was not compliant as per the requirements of the warning notice. The provider was also found to be in continued breach of Regulation 12 and 17, in relation to late visits and poor management oversight.

Westminster Homecare Ltd (Enfield/Waltham Forest) provides personal care services to people living in their own homes. They provide a wide range of personal care services and specialise in supporting people with dementia. At the time of this inspection the service was providing personal care services to 321 people living in Enfield and Waltham Forest.

A registered manager was in post at this 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 did not always receive their medicines safely and as prescribed. At the last inspection in August 2016 we found numerous gaps on medicine administration records (MAR's) which meant that we could not confirm whether people had received their prescribed medicines. We also found that where people had been prescribed high risk medicines, these had not been risk assessed, which meant that care staff were not provided with the appropriate information in order to mitigate or reduce the risks associated with the identified medicine. At this inspection we found that although comprehensive risk assessments had been completed in relation to people's identified health and care needs, medicines were not managed and administered safely. Where medicine audits focussed on identifying gaps on MAR's and addressing these with staff members, concerns that we found during this inspection had not been identified and addressed.

Feedback from people and relatives at the last inspection in August 2016 was noted to be negative around the issues of experiencing late calls. Staff told us and rotas confirmed that they were allocated very little or no travel time between calls. The provider was found to be in breach of Regulation 12 of the Health and Social Care Act 2008. At this inspection we found that very little had been done to improve this area of concern and that these issues were due to poor management of rotas. People, relatives and staff told us and rotas confirmed that they were allocated very little or no travel time between shifts which resulted in late visits and on some occasions missed visits.

Although some improvements had been made since the last inspection in August 2016 around risk assessments, the provider had failed in making improvements around the safe management of medicines and rota management to reduce the occurrence of lateness and missed visits. Lack of robust management oversight and governance meant that the provider had failed to identify the issues we found during this inspection. This meant that the provider continued to be in breach of Regulation 17 of the Health and Social Care Act 2008.

As part of the care planning process people's individual risks were identified and assessed to ensure sufficient guidance was provided to staff to enable them to keep people safe and free from harm. Staff told us about safeguarding people from abuse and confirmed the actions that they would take if they were to observe any signs of potential abuse.

Robust recruitment processes were noted to be in place to ensure that staff recruited by the service were safe to work with vulnerable adults.

Care staff told us and records confirmed that they received training in a variety of topics which was refreshed on an annual basis. Staff were also required to complete competency assessments on the specific topic they had received training on. However, completed assessments that we looked at did not evidence that the assessments had been adequately checked by the training manager.

People and relatives told us that they had been involved in decisions that had been made about their care and support needs. This was documented appropriately within the persons care plan. Care staff demonstrated a basic understanding of the MCA and how their actions had an impact on the people they supported. Care staff told us that they never presumed people lacked capacity and always asked consent and offered choice to people in every aspect of care delivery.

Care plans were comprehensive and person centred. The service completed a section called 'About me and my life history'. This detailed information about the person, where they grew up, previous occupation, information about family members as well as likes and dislikes in relation to the support that they received.

During the inspection we visited four people at their home. During this time we observed caring, positive and respectful relationships that staff had developed with the people that they supported.

The service carried out pre-service provision assessments which assessed whether the service could meet people's needs as well as obtain details on how the person wished for their care to be delivered.

Staff understood people's needs in relation to equality and diversity and that each person was different and possibly had different needs and requirements due to their religion, culture or sexual orientation.

People and relatives told us that they knew who to contact if they wanted to report any issues or raise a complaint. The service had a complaints policy and procedure in place which was made available to people

and their relatives as soon as they began receiving care. However, where common themes were noted around lateness and poor communication, the service was unable to provide any evidence in relation to any action that had been taken to learn and improve the provision of care, in response to the concerns that had been raised.

Staff received regular supervision and an annual appraisal. However, we received mixed feedback from staff on the support that they received from the office and senior managers. The culture of the service did not promote openness and transparency.

At this inspection we found continued breaches of Regulation 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. Medicines were not safely managed and improvements had not been made following the last inspection in August 2016.

Significant improvements had been made in relation to assessing the risks associated with people's care and health conditions. The service completed detailed assessments and provided in-depth information to staff on how to mitigate and reduce identified risks to people's health and support needs.

Safe and robust recruitment processes were in place to ensure that only staff, suitable and safe, to work with vulnerable adults were recruited.

Is the service effective?

Good

The service was effective. Staff demonstrated a basic understanding of the Mental Capacity Act 2005 and how this impacted on the day to day delivery of care. Care plans evidenced that consent was always sought and that people had agreed to receiving care and support.

Staff received regular training in order to effectively carry out their role. However, where competency based questionnaires were completed by staff following completion of training, we could not confirm that these assessments had been checked appropriately to affirm the staff members knowledge.

People's dietary requirements and preferences were clearly documented within their care plans. Where support with mealtimes was an assessed need, care staff clearly knew how people were to be supported.

Records confirmed that appropriate referrals were made to a variety of external healthcare professionals where this was an identified need.

Is the service caring?

Good

The service was caring. People and relatives confirmed that they received good care from staff who were respectful of their needs

and wishes.

We observed that care staff had developed positive and caring relationships with people and relatives and knew the people they supported very well.

People and relatives told us that staff maintained their privacy and dignity at all times.

People and relatives that we spoke with confirmed that they had been involved in the planning and delivery of care.

Is the service responsive?

Requires Improvement

The service was not always responsive. Although people and relatives knew who to complain to, common themes emerging from complaints were noted, which revolved around lateness and poor communication. These concerns were not always acted upon in order to make improvements.

Care plans were person centred and provided detailed information about how the person wished their care and support to be delivered.

Staff were knowledgeable about people's choices and preferences and they wished to be supported.

Is the service well-led?

Requires Improvement

The service was not always well-led. Although some improvements had been made since the last inspection in August 2016 around risk assessments, the provider had failed to make sufficient improvements around the safe management of medicines and rota management to reduce the occurrence of lateness and missed visits.

Lack of robust management oversight and governance meant that the provider had failed to identify the issues we found during this inspection.

Records confirmed that regular quality audits were completed on care plans, medicines management, spot checks and care worker report sheets. However, there was no evidence that the results of these checks were reviewed and analysed by management in order to derive learning and make improvements to the quality of care provision.

Staff gave mixed feedback about the support they received from

the office and senior management and felt that the culture was not always open and transparent.

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 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 inspection took place on 4, 5 and 6 April 2017 and was announced. 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 support us with the inspection process.

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

Before the inspection we looked at information that we had received about the service, action plans that the provider had sent to us following the last inspection in August 2016 and formal notifications that the service had sent to the CQC.

We looked at 34 people's care records and risk assessments, 20 staff files, 10 people's medicines charts and other paperwork related to the management of the service. We spoke with 10 people who used the service, 19 relatives, the registered manager, operations manager, deputy manager, compliance officer, three field care supervisors, two care co-ordinators, one administrator, one senior carer and 13 care staff. With people's permission, we also visited four people in their own homes.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in August 2016 and September 2016 we found multiple issues and concerns around the safe administration of medicines. The provider was found to be in breach of Regulation 12 of the Health and Social Care Act 2008. 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 this inspection we found that the registered manager and provider had not met the requirements of the warning notice and was found to be in continued breach of Regulation 12 of the Health and Social Care Act 2008 relating to safe administration of medicines.

Medication Administration Records (MAR) that we looked at stated 'blister pack' where medicines were administered from a pre-prepared blister pack. Where medicines were provided in loose boxes these were recorded individually on the MAR. Individual medicines contained in a blister pack were not listed on the MAR chart but were listed in people's care plans. However, some care plans had not always been updated to reflect changes in a person's medicine. For one person, one of their medicines was listed on the MAR but not in their care plan. Another person who had been assessed as being 'self-administering' was being supported with their medicines but this had not been reported to the office and the care plan had not been updated.

There were inconsistencies in what staff recorded on the MAR's and signing for medicines when administered. The service was not able to rely on these records to provide assurance that people were receiving medicines as prescribed or in line with instructions. One person had been prescribed eye drops. The MAR stated that the medicine was to be administered 'both eyes at night'. However, between 8 March 2017 and 13 March 2017 care staff had recorded that they had administered the drops in the morning and evening visit. On another occasion, the MAR chart showed that the same person had been administered another eye drop in the morning and evening when the eye drop should only have been administered in the morning.

Another person had been prescribed a patch used for the treatment of mild to moderately severe types of dementia. Records indicated that the person had received the patch twice in a 24-hour period when one patch should have been administered every 24 hours.

MAR charts that we looked at did not always record the name of the person, date of birth, GP, known allergies and dispensing pharmacy details. Individual MAR's did not always have the person's name recorded on them. In addition, on records that we saw, the name of the medicine, dose, frequency, route or commencement date had not been recorded. The provider's medication policy states under the section 'Record Keeping,' "The medication administration record will include the name of the drug the dose, the strength and the time to be given and any special requirement i.e. with food."

Where the service had kept a log of all missed visits that had been reported, we found that the service did not identify or report any medicine errors where as a consequence of the missed visit a person did not receive their prescribed medicines. For example, one person did not receive their teatime call on 14 March 2017 and a missed visit had been logged. Due to the missed visit the person did not receive their prescribed

medicines. There was no record that the client's GP or next of kin had been informed. During the inspection office staff reported they had made phone calls and had logged them but we did not see any evidence of this. The service had not completed an incident form as per the provider's medication policy which states, 'Medication errors include when medication is not given. Any medication error must be immediately reported to the line manager and the GP of the service user. All medication errors should be investigated with any necessary changes to training and procedures being made immediately.'

Another person did not receive a morning call on 12 March 2017. This had been logged as a missed visit. On this person's care plan it was recorded that they had been prescribed Co-dydramol to be administered one to two tablets every four to six hours when necessary and up to a maximum of eight tablets in 24 hours. Co-dydramol is a high strength pain relief medicine. The person had a missed administration of their medicines in the morning as a consequence of the missed visit. Further care calls were delivered at 15:30, 17:30, and 20:30 and on each of these occasions from records state that the person received two Co-dydramol tablets, a total of six tablets in five hours, which was in excess of the recommended dose.

All of the noted concerns above meant that there was a risk people may not have received their medicines safely and appropriately which could have an impact on their health.

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

At the last inspection we found numerous omissions in recording on people's MAR's where we were unable to confirm whether the person had received their medicines as prescribed. At that time the registered manager was unable to confirm whether people had or had not received their medicines as part of their care call. At this inspection we found that although missed signatures on MAR's were still visible, the audit processes that had been put in place clearly identified those missed signatures, clear explanations had been recorded as to why there was a gap in recording and staff supervisions and one to one meetings had taken place to address the issue with the relevant staff member. However, issues with safe administration of medicines as identified above had not been identified through the provider's audit process. This has been further reported on in the 'Well-led' section of this report.

Staff told us and records confirmed that staff received medicine training which was refreshed on an annual basis. Once training was completed, staff were required to complete a competency questionnaire, which was then followed up by regular observed competency assessments whilst a staff member was at a person's home. The observed assessments were completed by a senior carer or field care supervisor and where issues or concerns were identified, the staff member was spoken to and required to attend refresher training.

Feedback from people and relatives at the last inspection was noted to be negative around the issues of experiencing late calls. Staff told us and rotas confirmed that they were allocated very little or no travel time between calls. The provider was found to be in breach of Regulation 12 of the Health and Social Care Act 2008. At this inspection we found that the provider had failed to appropriately manage the rotas so as to allow sufficient travel time between calls and did not take into account the distance between each call, despite this being previously identified. Therefore we found that the provider had failed to ensure good governance and management oversight of this issue and we have reported in detail about this issue under the section of 'Well led'.

At the last inspection in August 2016, we found that the service had not completed appropriate risk assessments for people with individual risks associated with their health, care and support needs. This

included risk assessments for people taking high-risk medicines as well as risk assessments for people where the service had identified known risks such as alcohol dependency, behaviour that challenged, risks relating to dementia, epilepsy, swallowing difficulties, falls and serious mental health conditions. A warning notice had been issued for a breach of Regulation 12 of the Health and Social Care Act 2008 in relation to the lack of risk assessments. At this inspection, we found that the provider had met the requirements of the warning notice and were now compliant with the breach.

At this inspection we found that the service had put in place risk assessments for high-risk medicines. These were to be reviewed on an annual basis or sooner if changes were reported. For one person who had been prescribed a high-risk medicine, an extensive risk assessment relating to this medicine was available with guidance for staff of interventions they should follow if concerns arose. Another person who had been prescribed a medicine to control seizures had a risk assessment and guidance to staff in place related to the medication.

As part of the care planning process people's individual risks were identified and assessed to ensure sufficient guidance was provided to staff to enable them to keep people safe and free from harm. As well as generic environmental risk assessments of the person's home, other individualised risk assessments completed covered risks associated with urinary tract infections, epilepsy, moving and handling, falls, pressure sores and mental health conditions. Care staff were provided with an initial quick reference overview of all risks associated with the person's care and support needs as well as detailed fact sheets which gave in-depth information about the risk and how to manage and support the person in order to reduce or mitigate the risk. Staff that we spoke with confirmed that care plans contained the relevant information about people's identified risks so that they could support people appropriately. One staff member told us, "The care plan gives information about the person and their risks. I had a friend who was diabetic so I know what to do but the care plan also tells you what to do."

People and relatives told us that they felt safe when receiving care and support from the staff allocated by the service. People's comments when asked if they felt safe included, "Yes, I feel safe yeah", "Yes, I have not had any cause to feel otherwise" and "With [Names of care staff] I feel very very safe." One relative when asked if they felt the person being cared for was safe replied, "Yes, they take good care of him." Another relative commented, "Oh definitely, definitely."

All staff received safeguarding training as part of their induction programme. Records confirmed that safeguarding training was refreshed on an annual basis and each staff member was required to complete a competency questionnaire following the training. Staff demonstrated a good understanding of the term safeguarding and the actions they would take if they suspected any form of abuse to be occurring. One staff member said, "I would report any concerns straight to the office." Another staff member told us, "Safeguards put in place to protect the client and protect me. Make their environment safe and make sure they are protected from abuse and neglect."

Staff also understood the term 'whistleblowing' and the steps they would take to report their concerns. One staff member said, "I would take my concerns further. I would call the police." Another staff member explained, "Whistleblowing is about notifying someone of something going in a company. I would report my concerns to the Care Quality Commission (CQC)."

Since the last inspection in August 2016 the service had received and raised a high number of safeguarding concerns all of which had been reported to the local authority and the CQC. We saw detailed logs of each safeguarding concern that had been reported. Documentation included clear investigation reports with outcomes and actions taken as a result of the concern that had been raised. The service was pro-active

when identifying and reporting any concerns or signs of abuse to ensure people were kept safe and free from harm.

We looked at 20 staff files and found that the service had robust systems in place to ensure that checks were appropriately completed confirming that staff recruited were safe to work with vulnerable people. Checks included proof of identity, criminal record checks, satisfactory references from previous employment and right to work in the UK. Staff were unable to commence work until these checks had been completed.

All care staff had full access to personal protective equipment (PPE). We observed that care staff were able to come to the office and collect the equipment that they required.

Good

Is the service effective?

Our findings

We received mixed feedback from people and relatives about the skills and knowledge of care staff who provided care and support to them. One person told us, "Yes for me I think they are [skilled and knowledgeable]. They do understand my needs." Another person said, "I cannot fault them in any way." Relatives comments included, "Yes, I really think the carers know exactly what is going on and how best to help him", "I don't know how to answer that one. You've got one or two good ones, the rest are not", "I would hope so but I wouldn't say he has always been looked after well" and "No, [Relative] has a catheter and is quite often laying in soaked sheets, clothes, it does make you wonder how well trained they are."

Care staff told us and records confirmed that they received training in a variety of topics which was refreshed on an annual basis. Feedback from staff included, "Training is good. The training is very precise" and "I am up to date with my mandatory [training]. The email usually gets sent out and we come into the office or do it online." Training was provided on mandatory topics such as moving and handling, first aid, safeguarding and first aid. All newly appointed staff were required to attend a five day induction course was based on the Skills for Care guidelines and the Care Certificate. The Care Certificate is a training course that covers the minimum expected standards that care staff should hold in relation to the delivery of care and support.

Once training was delivered to care staff, we saw that staff were required to complete competency assessments on the specific topic they had received training on. However, completed assessments that we looked at did not evidence that the assessments had been fully checked and where staff had answered questions incorrectly, these had not been highlighted to the staff member. We highlighted this to the registered manager who confirmed that they would ensure the newly appointed training manager was made aware of this identified concern.

Most staff we spoke with told us that they received regular supervision and support. Records confirmed that staff received supervision through a variety of methods which included one to one supervision, observational based supervision and spot checks. Records also confirmed that staff received an annual appraisal which looked at their overall performance and personal development. One staff member told us that supervisions were done frequently. A second staff member said, "I receive supervision every two months and I am able to express my concerns."

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

We checked whether the service was working within the principles of the MCA. Care staff demonstrated a basic understanding of the MCA and how their actions had an impact on the people they supported. Care staff told us that they never presumed people lacked capacity and always asked consent and offered choice

to people in every aspect of care delivery. Comments from staff included, "You tend to go in and do the usual stuff. I approach them and ask, sometimes they say no. I ask them first and talk them around" and "If some people can't make decision for themselves. They need support to make decisions such as an advocate." There were some staff that we spoke with who did not know what MCA was and could not remember if they had received any training in this area but were able to explain the importance of asking for consent and offering choice.

Care plans recorded and confirmed that people had consented to their care and support and where people were unable to consent to their care, this had been evidenced in the person's care plan with the relative or next of kin signing on their behalf with the appropriate authority to do so. People and relatives confirmed that staff were respectful of their choices and wishes and always sought consent. Comments from people included, "I can make the decision and they do ask me" and "They wash, I can walk and I can get to the toilet by myself. When I came out of hospital I was taught how to do certain things. In the morning when I go to the toilet they wait till I am ready." Relatives feedback included, "No, he can't talk. They discuss it with me" and "Yes I suppose so, I don't go upstairs with them."

Care staff were not involved in menu planning for people and were not always involved in monitoring people's nutrition and hydration as they would only be present at the person's home at certain times throughout the day for a specific time period. The service did support people with preparing meals or heating up pre-ordered ready meals. People and relatives confirmed that where required, care staff supported them with their nutritional and hydration needs. One person told us, "They will get a sandwich and help me with breakfast." A relative commented, "They will heat up something for her. They usually just give her whatever she wants to eat." Care plans noted information about people's dietary requirements. This included specific information about any cultural or religious requirements, likes and dislikes.

Care plans provided information about people's current health and medical needs. Records seen confirmed that where required, appropriate referrals had been made to other health care professionals such as the GP, occupational therapist and physiotherapist. Care staff knew the people they supported and knew who to contact if they identified any concerns about people's health to ensure people received the appropriate care and support. One person said, "Yes, they have called a GP or an ambulance a couple of times. They do recognise if I'm not well." One relative told us, "Yes because if anything goes wrong like today, the staff said to me she was not swallowing properly and the doctors been in to see her today. We work as a group."

Good

Is the service caring?

Our findings

People and relatives were positive about the care and support that they received and told us that staff understood them and their needs. Comments from people when asked if staff were caring included, "Yeah, they are always caring if anything is wrong they ask me if I want them to get a doctor, If I'm not feeling well they would check if I'm okay to be left", "Definitely, they want to look after me, to make sure I've got the things I want before they go" and "Yes I do. They talk, joke and laugh, they give me mental support when I'm down."

Relatives feedback about staff included, "Just the way they talk to us and seem to understand exactly what is going on. They try their best to help us", "They are very caring all of them. Saturday and Sunday we get different people. Yep, very happy with the service" and "They are very nice and accommodating. It's the way they treat her."

During the inspection we visited four people at their home. During this time we observed caring, positive and respectful relationships that staff had developed with the people that they supported. We observed staff to knock on the door and introduce themselves before entering the home as well as asking the person what they would like them to do before carrying out any tasks. We observed people to be comfortable around staff and we saw light hearted and humorous conversations taking place. One person told us, "[Name of carer] is absolutely golden. He looks after me better than my own family." Another person light-heartedly told us, "[Name of carer] is my favourite. [Name of carer] is my second favourite and [name of carer] is my third favourite."

People and relatives that we spoke with confirmed that they had been involved in the planning and delivery of care. People told us, "Yes, the lady who came first time from Westminster she asked me what's important" and "Yes I was. When they came to see me they helped me decide what I needed." Relatives comments included, "We had a chat with I think it was the manager or supervisor or something. We spent over an hour going through the things she liked and what she needed" and "Yes, We talked about his likes, dislikes and health problems. It is in his care plan."

Care staff we spoke with were very passionate about the work that they did and told us that they were there to support people in whichever way they could. One staff member said, "A lot of people get lonely. I bring them enjoyment. If I leave them feeling happy then I have done a job well done." A second staff member told us, "I get so much out of it as I am helping others. I have three main regulars." Staff were able to clearly explain how they respected people's privacy and dignity whilst supporting them with their care needs. Explanations given included, "Keep covered. Close door and if people about and you can't shut the door, ask them to leave" and "If they want to get changed or go to the toilet, leave them for a few minutes to give them privacy."

People and relatives confirmed that staff were always respectful of their privacy and dignity and gave numerous examples of how staff delivered care that maintained their privacy and dignity. Examples included, "Just the little things like knocking or waiting for him to be alone in his bedroom before changing

him", "Yes, I am very, very happy, very pleased with how they treat me" and "Yes, they are really good, they are so much better than the care home as they know what he likes."

Staff understood people's needs in relation to equality and diversity and that each person was different and possibly had different needs and requirements due to their religion, culture or sexual orientation. One staff member told us, "I treat everyone as equal, doesn't matter where they are from. Whoever I work with it doesn't matter." Another staff member said, "I would treat everyone the same. I would treat people the same as how I would like my own parents to be treated."

Requires Improvement

Is the service responsive?

Our findings

People and relatives told us that they knew who to contact if they wanted to report any issues or raise a complaint. People told us, "Yeah if I can't get an answer from [name of registered manager] who is the manager then I would have to contact Westminster Homecare, the office" and "Oh yes, I have done about the girl who wasn't very helpful. They responded by stopping her coming." Relatives comments included, "Yes, I would ring the office and speak to someone there" and "Yes, I would ring the office and speak to someone there."

The service had a complaints policy and procedure in place which was made available to people and their relatives when they began receiving care. We looked at complaint records since the last inspection and found that complaints were appropriately recorded with details of the complaint, investigations that had been completed, outcome of the complaint and a response letter which had been sent to the person complaining with a clearly defined response and outcome.

However, out of the 83 complaints logged for 2016 and 22 complaints logged for 2017, common themes were noted which revolved around lateness, poor communication and the second carer not arriving for the person's care when the package of care required two care staff to attend at each call. People and relatives that we spoke with also told us that timekeeping was an issue and that carers were regularly between 30 minutes and one hour late for most calls. Comments from people included, "Well it depends. I've given up saying where's the carer. Eight o'clock was agreed but they will say various times was agreed. I requested an early morning call. I requested 7am I only get that on a Saturday and Sunday" and "The early morning one is usually on time the evening one can be late. Relatives told us, "Carers are on time as best as they can. You have to make allowances but there is no communication from the office to inform you that carers are running late. Carers tell the office but the office don't communicate" and "I don't recall a time when they have been on time. This is the only thing I don't like about this service." During the inspection the service was unable to provide any evidence to demonstrate that action had been taken to learn and improve the provision of care, in response to the concerns that had been raised.

Care plans were person-centred, detailed and gave clear information about the person, their likes and dislikes as well as their choices and wishes on how they wished to have their care and support delivered. The service carried out pre-service provision assessments which assessed whether the service could meet people's needs as well as obtain details on how the person wished for their care to be delivered. One person's care plan stated, "It is very important for me to have care workers to be on time and regular and ensure they have the key to my property." Another care plan entry stated, "Care worker will then need to prepare my breakfast which will be porridge, two slices of toast with butter and a cup of tea with one sugar."

As part of the care plan, the service completed a section called 'About me and my life history'. This detailed information about the person, where they grew up, previous occupation, information about family members as well as likes and dislikes in relation to the support that they received. As part of this collation of information, people were asked their preferences in relation to whether they wanted a male or female staff member to support them. Care plans were reviewed on an annual basis as a minimum and more frequently

where concerns or changes were noted. Risk assessments were also reviewed as part of this process.

Care staff told us that care plans were available at the person's home and gave them information about the person and the care and support that they received. One staff member told us, "Care plans give us information about the person and about their risks." Care staff understood the term person centred care and were able to give examples of how they delivered person centred care to the people they supported. One staff member said, "Sometimes they don't want to get out of bed. I do a bit of laughter and a joke."

Staff members completed care worker visit sheets after each care shift and recorded the date of the visit, the time the carer arrived and the time they left and the tasks that were undertaken. Most report sheets that we looked at were task focused. We saw some positive examples of person centred reporting within the report sheets. For one person the care staff had recorded, "Client a bit upset and teary on arrival. Explained to me she had phoned some friends and they were not very nice to her on the phone. Made her a coffee and a sandwich and starting chatting about different things so she would forget that she was upset."

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in August 2016, the service was found to be in breach of Regulation 17 of the Health and Social Care Act 2008 as the audits that the service completed had failed to identify issues we identified during the inspection. We also found that the registered manager did not have adequate oversight of the service. During this inspection we found that the service had not improved sufficiently in order to address the concerns we found at the last inspection.

Medicine audits were being completed by the deputy manager, compliance officer, field care supervisors and senior carers. The registered manager told us that monthly audits of medicines had started in January 2017. The medicines audits that we looked at had identified gaps in the recording of the administration of medicines. However, they did not always recognise and identify the issues we found during this inspection, such as missed medicines and unclear recording.

We asked the registered manager and operations manager about their management oversight and how they checked the audits for quality and we assured that the audits were being completed effectively. The registered manager confirmed that they had not reviewed any of the completed medicine audits and had not completed any medicine audits themselves. Both the registered manager and operations manager confirmed that the audits had not been completed properly but that this was not due to lack of management oversight but was due to the lack of training provision on how to complete medicine audits, which they had not addressed.

We also spoke to the staff who were responsible for completing the audits to ascertain the level of training and support that they had received in order to complete the audits effectively. We were told by all staff that we spoke with including the compliance officer and field care supervisors that they had received the same mandatory training in medicines which all care staff received. They said that they had not received any specialist training in auditing processes and specifically what needed to be looked at when auditing medicines management. The directive from senior management was that audits needed to identify gaps in recording which then needed to be addressed with care staff in question.

The registered manager confirmed that medicine audits and care plan checks were the only quality monitoring that was completed. No other form of audits or checks were completed on any other areas of service provision by the registered manager or other senior managers. Field care supervisors, the compliance officer and senior carers all carried out spot checks of care staff, telephone monitoring, care worker visit report sheet checks and reviews to ensure that care provision was appropriately received by people. There were systems in place which alerted staff to the number of reviews, spot checks and monitoring checks which needed to be completed on a weekly basis as per their allocated key performance indicators. The registered manager held oversight of those spread sheets to ensure these were taking place. The registered manager and operations manager reviewed and analysed all complaints, missed visits and lateness on a weekly basis. However, trends and patterns had not been identified so that learning could take place and improvements made to the quality of service provision.

We saw the results of an audit that was completed by the provider in February 2017 which looked at each key question as set by the Care Quality Commission (CQC) and detailed the issues that were found and the improvements that needed to be made. However, the audit did not identify any of the issues we found during this inspection. An action plan had been developed as a result of the audit with improvements to be addressed within six months from the date of the audit. However, the action plan did not provide any detail of actions that had been taken to address the concerns they had found.

During this 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 looked at nine staff member rotas which clearly evidenced that either no travel time had been allocated or only a five minute timeframe had been incorporated between each care visit. Care staff that we spoke with all told us that the care co-ordinators did not allow for travel time when setting their rotas, despite telling the care co-ordinators on a number of occasions that the rotas were not manageable and that they were always going to be late in arriving to each shift. As a response to tackle these concerns, care staff were told to start their provision of care early so that rotas could be managed. Care staff did not receive any additional payment for starting work early. Care co-ordinators told us that care staff received their rotas in advance each week, unless urgent changes to rotas needed to be made, Some care staff told us that they received their rotas in the evening on a regular basis.

The provider had very little oversight on this identified issue and communicated the message that a five minute travel time allocation between visits was the process to be followed. According to the provider's internal audit completed in February 2017, scheduling of rotas with a five minute travel time allocation was acceptable and no consideration had been given to calculating travel time according to distance between care visits.

We highlighted these issues to the registered manager who confirmed that lateness was an identified issue within the Enfield team. 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. Some people and relatives continued to provide feedback which was consistent to the feedback received at the last inspection around lateness and not being informed that the care staff were running late. We spoke to 10 people and 19 relatives. Three people and six relatives commented about late visits and poor communication.

People told us, "Yeah sometimes they might be a bit over, the trouble is I'm never told when they are going to be late. One time they came at 17:40 and one time they came at 19:00 I told them to go away I was washing up" and "The carer usually come 10.30, 11 o'clock. I know it is difficult the office is supposed to inform me they are going to be late."

Relatives comments, when asked about whether staff arrived on time, included, "Most of the time they are supposed to start at 08:30 and they start at 09:30 or 09:50", "They are usually late. Anything from 10 minutes to an hour. No one usually calls to let you know and you have to wait" and "Always always late. I don't recall a time when they have been on time."

We looked at 11 staff members rotas over the four months prior to the inspection and found that care staff were allocated five minutes or no travel time between each allocated care shift. No consideration had been given towards calculating the distance between each person's address and allocating travel time accordingly. We saw examples of where staff were required to cover a distance of four miles by public transport with no travel time allocated and half a mile by public transport with only a five minute travel time

allocation. Where staff had been reported by the person receiving care or their relative for lateness or missed visits, we saw supervision records stating that the person would not have been able to reach to the person as they had no travel time allocated between care shifts.

Care staff that we spoke with confirmed that rotas were not manageable due to no or very little travel time allocation. Comments from staff included, "Sometimes I could do with more travel time. If I'm on a long day, I need travel time", "Sometimes I am 30 minutes late. Now they are saying they are putting travel time. We start earlier and finish later to fit in travel time. I don't get paid travel time so I will make my availability shorter", "I am an early person. I start at 6am. If I look on the rota I will be late with my calls. My people [SU's] know my times. Times they like and times I like" and "You don't get travel time between calls."

We spoke to three care co-ordinators about the rotas and how travel time was incorporated into a staff members rota. We were told that five minute travel time was sufficient as care staff worked in clusters in one specific area to ensure minimal travel time. However, the rotas that we looked at did not confirm that this was actually happening. One care co-ordinator stated, "They have up to 30 minutes to run late so it's okay, they can make up their time." The same care co-ordinator also stated, "They [care staff] start early so will only be five to 10 minutes late but have flexibility in between so can make up the time."

We informed the registered manager of our findings as well as the comments that were made by the care co-ordinator. In response to the comments the registered manager told us that people were told that the service would try and provide care at their preferred time but in the event of lateness, their policy clearly stated that staff should only have a 15 minutes window to be late and that would be in emergency situations only.

The service kept logs of all reported missed visits and lateness. From August 2016 to April 2017, the service had recorded a total of 78 missed visits, majority of which had been recorded in Enfield.

Some people continued to experience late calls and missed visits. As a result, some people were not always being supported at their preferred time especially in the mornings, supported to meet their needs. This continued to put people at risk of harm.

The service provided care in the London Boroughs of Enfield and Waltham Forest. Concerns regarding lateness and missed visits were more prevalent in Enfield. The service operated an electronic call monitoring system in Waltham Forest but this was not in place for Enfield. In Waltham Forest, care staff were required to log in and out through the telephone's in people's homes. The service was able to continuously monitor staff timekeeping as well as check to ensure staff were staying at a person's home for the correct allotted time.

For care provision in the area of Enfield, the office had to rely on care staff to inform them if they were running late or if they were unable to attend to a call allocated on their rota. The office also relied on people to call the office to inform them that the care staff had not arrived. People and relatives told us that they did not receive a telephone call from the office to inform them that a staff member was running late although care co-ordinators we spoke to told us that they always made sure the person affected by lateness was informed. We saw evidence of regular telephone monitoring that was carried out. However, where feedback referred to late or missed visits, we did not see that action had been taken to address the issues. We also did not see any evidence of management oversight which reviewed lateness and missed visits with a view to implementing learning and drive improvement.

The provider had failed to ensure good governance and management oversight of issues as identified

above.

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

Staff that we spoke with told us mixed views about the level of support that they received from the office and senior managers. Some staff were positive and told us, "Management are very supportive, everyone is nice and we ask each other for advice", "Very friendly. All of them are friendly" and "I feel like I do get supported by my colleagues." Negative comments included, "I have no loyalty to Westminster", "The more you complain, the less work you get." and "They [office staff] don't know anything about confidentiality." Out of 24 staff members that we spoke with, nine staff members made comments which indicated a negative culture, poor morale and lack of support. The culture of the service did not promote openness and transparency. For example, supervision records that we looked at noted that care staff were disciplined for being late to care calls even though their rotas did not allow them sufficient travel time.

On-call systems were in place which operated outside of office hours so that care staff could contact a senior member of staff if an issue was noted or an emergency arose. We received mixed feedback from care staff about the responsiveness of senior staff when they tried to call them. One staff member told us, "I call the office a bit. They usually answer", "When I call I get an answer. They answer and tell us what to do", "If I call during the week, yes. At the weekend they don't answer. I called once in December and they didn't answer and I couldn't leave a message. I had to contact the family and we had to call the ambulance. The office didn't call me back" and "It is very hard to get through. The telephone will ring and ring and only sometimes they call you back."

Staff told us and records confirmed that regular care worker forums were held which discussed topics such as rotas, lateness, policies and procedures and care plans. Care staff told us, "Regular meetings. Care forums. Same old thing. We go through policies for example no response, confidentiality, whistleblowing" and "I come when I can. I find them helpful. We discuss everything in general about day-to-day stuff that affects your work. A copy of the minutes are sent out to you if you can't attend."

People and relatives we spoke with told us that although they did not know who the registered manager was, they knew who to speak with about the care provision that they received. Comments from people included, "I don't know exactly who's the manager but whenever I ask for something special, I've got the number", "Yeah, I think she came round here last year when I got some issues" and "I'm not sure if [name] is the manager or supervisor, she does the reviews. Very helpful." Relatives told us, "I don't know. I would just ring them. Never had a problem getting hold of anyone", "No. To tell you the truth when you ring the office the person you talk to is a carer herself. I ask to speak to the manager I think is [name] but nothing is done about it" and "No, I've not met anyone from management."

Overall, most people and relatives told us that they could not remember ever receiving a questionnaire from the provider asking about the quality of care that they received. Most people and relatives made comments that they either received a visit by someone from the office or that they received a telephone call asking them about the care that they received. We saw records confirming that an annual questionnaire was carried out in late 2015, the results and analysis of which was sent to people and relatives in January 2016. Overall feedback was seen to be positive. The letter outlined the actions and improvements the provider proposed to take as a result of the questionnaires. The next questionnaire was scheduled to be sent out over the forthcoming months.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed or recorded safely. Care visit were often late. Care workers were often booked for back to back visits or with only five minute travel between visits. People did not always receive care at the times that they were supposed to.

The enforcement action we took:

We issued a warning notice on the registered provider and registered manager on 19 May 2017.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to adequately implement improvements following the last inspection in August 2016. Audits of the service continued to fail in identifying issues found during this inspection. The registered manager and provider did not have adequate oversight of the service.

The enforcement action we took:

We issued a warning notice on the registered provider and registered manager on 19 May 2017.