Westminster Homecare Limited

# Westminster Homecare Limited (Aylesbury)

## Inspection report

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Website: www.whc.uk.com

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21 September 2017

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| 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

We undertook an announced inspection of Westminster Homecare Limited (Aylesbury) on 14, 15 and 16 September 2017.

Westminster Homecare Limited (Aylesbury) provides care and support to people in their own homes with personal care needs. The agency provides support and personal care to children, younger adults and older people. At the time of our inspection 128 people were using the service.

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.

Care delivery was not always effective as some people experienced delays in their care calls as people did not receive their care at the agreed time. This put people potentially at risk. One person commented; "As far as it goes, the care workers I get are managing well. But I don't get the same care workers all the time".

People told us they felt safe when staff delivered their care. Staff knew how to keep people safe, for example, trip hazards. Staff understood their responsibilities in relation to safeguarding people.

We saw staff had received regular training to make sure they stayed up to date with recognising and reporting safety concerns. Staff were confident their training on how to protect people from harm prepared them to protect people from abuse.

The service had systems in place to notify the appropriate authorities where concerns were identified. People received their medicine as prescribed.

The service had safe recruitment procedures and conducted background checks to ensure staff were suitable for their role.  Where risks to people had been identified, risk assessments were in place.

Although we saw care worker training had taken place, some people were not confident staff had received the right training to look after them. Staff also said they would like more training to ensure they knew how to look after people.

Staff told us they had adequate induction prior to them looking after people and they had regular supervision and overall felt supported.

Staff knew their responsibility under the Mental Capacity Act 2005. People were supported with their nutrition and their health needs and their preferences were respected.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People told us care staff were very friendly, caring and attentive to their needs. They said they benefitted from caring relationships with the regular care staff and their dignity and respect was maintained when staff delivered care. Comments included; "They are kind and caring. They are excellent" and "The care workers are very pleasant".

People said they were mainly involved in their care and their independence was actively promoted. Staff sought people's consent and involved them in their care where possible.

We saw people's care files were maintained with the necessary information in the office. However, people's care files in their own homes did not contain the same level of information, were incomplete or in one case, the care file was absent.

Although systems were in place to record complaints. We saw complaints had been raised about the poor delivery of peoples' care calls. People we spoke with knew how to raise concerns, but comments received demonstrated people were not always confident their concerns would be actioned or the complaints policy followed. One person commented; "I have spoken to the agency regarding the care workers, but they don't listen to you in the office. You are just a number to them, not an actual client".

People and staff were not confident the service was well managed. They said communication was the main problem between people, staff and the office. One person said; "Overall the management is ok, but lately they are more disorganised". Staff told us they did not always feel valued and improvements were needed, for example, they needed their care rotas timely. This was also confirmed when we spoke with people.

The service had systems to assess the quality of the service provided, but these were not always effective.

Although staff received a newsletter, we saw staff meetings were infrequent. Staff and people told us the management team were not always approachable and there was a poor level of communication within the service.

The service sought people's views and opinions and were in the process of acting on these.

We found three breaches of the Health and Social Care Act 2018 (Regulated activities) 2014. You can see what action we have told the provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

There was not sufficient staff to meet people's needs and staff were not effectively deployed.

Staff knew how to keep people safe, how to identify potential abuse and knew their responsibility to report any concerns of abuse.

Risks to people were identified and risk assessments were in place to manage these risks.

People told us they felt safe.

People told us they had their medicine when needed.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

People were not always supported by staff who had the training and knowledge to support them effectively.

Staff received support and supervision and had access to further training and development.

People had access to healthcare services and where people needed support with their nutrition, this was well maintained.

### Is the service caring?

**Good**

The service was caring.

Staff were kind, compassionate and respectful and treated people with dignity and respect which promoted their wellbeing.

Staff gave people the time to express their wishes and respected the decisions they made. People were involved in their care decisions.

The provider and staff promoted people's independence.

## Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans held in the office were personalised and mainly provided clear guidance for staff on how to support people. However, people's care plans in their homes did not contain the same level of information.

People knew how to raise concerns, but were not always confident action would be taken.

People's needs were assessed prior to receiving any care to make sure their needs could be met.

## Is the service well-led?

Requires Improvement

The service was not always well led.

Communication was poor for staff and people who use the service. People and staff told us the service was not always well managed.

There was not a positive culture and the registered manager did not demonstrate they looked for continuous improvement.

The service had systems in place to monitor the quality of service but these were not always effective. There were governance systems in place but service quality concerns were not always actioned.

# Westminster Homecare Limited (Aylesbury)

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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 was the first inspection and rating of Westminster Homecare Limited Aylesbury. The inspection took place on 14, 15 and 16 September 2017. It was an announced inspection. We told the provider two days before our visit that we would be coming. We did this because the manager is sometimes out of the office supporting staff or visiting people who use the service. We needed to be sure that someone would be available. This inspection was carried out by one inspector and an Expert 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.

Before the inspection, the provided completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with 14 people by telephone, visited 10 people in their homes, spoke with three relatives, a healthcare professional and seven care staff. We also spoke with the registered manager, the deputy manager, the operational support manager and the national quality manager for Westminster Homecare Limited. We looked at 12 care records, four staff files and medicine administration records. We also looked at a range of records relating to the management of the service. The methods we used to gather information included pathway tracking, which captures the experiences of a sample of people by following a person's care route through the service and obtaining their views about their care.

We reviewed any notifications we had received about the service. A notification is information about

important events which the provider is required to tell us about in law.

Requires Improvement

# Is the service safe?

## Our findings

There were not sufficient staff to meet people's needs and staff were not always deployed effectively. People told us there were occasions when staff were late or did not turn up and people were not informed. They said this mainly happened at weekends. People told us they would like a rota so that they knew who was coming to deliver their care. We were told by the deputy manager that people were offered the option of a rota, but only 18 people had taken the option of receiving this in the post or by email. They said people could also access the rota using their on line records system. However, people we spoke with were not aware of these options. Out of the fourteen people we spoke with on the telephone, nine people had experienced disruption to their care call. People's comments included; "They don't come on time and I am thinking of changing my carers. I am fed up with it"; "My impression is they are in a rush. Every other weekend chaos reigns, the timings are well off"; "They will not stay for the contract times, they arrive late. They don't phone. I have to stay most mornings as I am waiting for the carer. I do my medication myself when they should be doing it. Some carers come at 5pm, and it should be 9pm"; "They are always late"; "At the weekend it's agency workers. They don't finish everything they are supposed to"; "Not really (they don't stay the allotted time), at night time. It's slam, bam, thank you man, at night. When a care worker comes you don't know, they are from Luton, so they don't know the area" and "They have told me a couple of times they cannot do my call. I have just phoned them to say I would do it myself and told them not to bother".

One person we spoke with on the telephone told us; "Not they don't (come on time). They are supposed to come before 9 o'clock and they have only gone now". This was at 12.45pm. One relative told us; "They will phone to say 'we are having a horrendous day' and I have told them not to send anyone". The relative told us they provided the care to their family member despite struggling due to their own health problems.

People we visited also told us they also experienced disruption to their care calls. Their comments included; "There is not enough back up staff. Staffing is a problem for them. It's a daily occurrence when staff are not available"; "It's all about staffing. I wish I could have regular care workers"; "It's hit and miss what I get. Sometimes they are very late for my evening meal call, but I know someone will come at some time"; "On the whole they are good. Except at weekends staff are always erratic. They are either sick or on holiday"; "About three weeks ago they were 2.5 hours late, but they did not tell us. There is no indication when they are coming"; "I get no rota of who is coming and there is no continuity of care. About four or five weeks ago I realised no one had come and it was midnight and I wanted to go to bed. I called them and they came within about 15 minutes"; "They rush my care and are always looking at the clock. They don't do all the tasks, they don't have time"; "They don't let me know if they are going to be late. It would be lovely if they would"; "One night it was 11.30pm when they arrived, it should have been 9.30pm. They told me they were short staffed that weekend"; "This morning they were short staffed and I did not get my breakfast until 10am. It is usually 9am" and "It's no good phoning the office before hand to see who is coming as the care workers don't know until on the day!". People also told us, at times, when two care workers were needed to assist them with their care, two care workers would not turn up. This left the care worker to carry out the care call on their own.

We asked staff about staffing levels, they told us; "Staffing is an issue, it's really difficult to take my holidays";

"Rotas are the problem, we don't get them in time. They will sometimes call us at 11pm at night to tell us we are starting at 7am the next morning. I have little time off and I don't get much of a personal life as I cannot plan anything"; "There is not enough staff, a lot have left recently. We use agency or bank to cover. There is poor management of staff as some don't turn up on time for the first call and this makes us late and we cannot catch up"; "It's frustrating as we tell the 'on call' person that we are going to be late, but they don't always let people know"; "Rota system is a problem as you don't know what you are doing from day to day"; "We need our rota's a week in advance. It's difficult when last minute cover requests come through"; "I know some morning calls are for 9am, but they (staff) don't get there sometimes until 11am"; "and "I feel sorry for people, there is no continuity of care for them".

We discussed this with the registered manager. They told us that disruption to care calls was mainly due to traffic delays and they felt agency staff were the problem. They said they were not always from the area and so struggled to find the locations. They said that they had now started to include directions to people's properties on the rotas for staff and they were planning to send out staff rotas in advance. They also told us they had the care call scheduler leave at the end of July 2017 which had an impact on scheduling care calls. They said they were hopeful they would be able to appoint another scheduler by the end of October 2017.

We saw there had been 28 missed calls since January 2017. The reasons recorded for these varied. The main reasons were, rota updates had not been forwarded to care workers to notify them of the changes to their rotas and care workers had not turned up for the call and had not notified the office.

The service used an electronic visit recording system. We noted from the information provided at the time of the inspection that people did not always receive their care call at the agreed time. Following our inspection we were informed there was a 15 minute leeway arrangement with the local authority who contracted with the service. However, comments received from people did not demonstrate they were aware of this agreed leeway of 15 minutes. An analysis was carried out following our visit by the provider of the call times for the period between 28 August to 15 September 2017. This showed 11% of calls were delivered earlier than scheduled; 21% of calls were later than scheduled and 68% of calls were within the 15 minute leeway period. The late calls were up to 2 hours late in some cases.

This meant staff deployment was not effective to ensure people received their care as scheduled. This potentially put people at risk as, on occasions, people were left without their care provision.

This is a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We did however receive some positive comments about the care calls people received. These included; "Yes, if they are not going to be on time, they sometimes telephone and say they are running late. They normally come on time"; "My regular care worker normally arrives 10 minutes either way. But I am not always informed unless I contact the office"; "They have been much better recently. Yes, they usually give me a ring if going to be late"; "Sometimes they are late, but they ring up and tell me. It's not often I have to chase"; "They never leave early. They don't rush me at all. I normally get the same one (care worker) and you get to know them"; "They do what they are supposed to do, I am not rushed" and "Yes, they are usually on time. They do phone if they are going to be late".

Records relating to the recruitment of staff showed relevant checks had been completed before staff worked unsupervised with people. These included employment references and Disclosure and Barring Service (DBS) checks. These checks identified if prospective staff were of good character and were suitable for their role. This allowed the registered manager to make safer recruitment decisions. Some staff told us they had a telephone interview prior to inviting them in for the formal interview. Records showed as part of the

interview, staff were asked specific questions and tests were conducted to ascertain the applicant's abilities and suitability for their role. For example, care and medication scenarios. This was confirmed by the staff we spoke with. Staff told us they shadowed other care staff before being allowed to work on their own. This ensured the staff members competence and confidence was measured before working alone with people. One staff member said "I was not allowed to work on my own until my DBS was received". In the care worker files we looked at, we saw that each staff member had not started work until after their DBS had been received. This meant the provider ensured people were suitable to work with vulnerable people.

People told us they felt safe with the care they received. Comments included "I feel safe when they (staff) are helping me"; "I feel safe in the hoist and they (staff) know what they are doing"; "Oh yes, I do feel safe"; "The staff are good with the hoist and I always feel safe"; "I feel safe, I have a bath lift and my walking frame"; "I feel safe when they deliver my personal care" and "Yes, I feel quite safe with them". We saw some people had emergency pendants or bracelets to wear to enable them to call for assistance in case of an emergency. One person said "In an emergency I have my bracelet. I have got their telephone number and I can also phone them".

People were supported by staff who could explain how they would recognise and report potential abuse. Staff told us they would report concerns immediately to their manager or senior person on duty. Most staff were also aware they could report externally if needed. Staff comments included; "It's about how we make sure people are kept safe. I know the different types of abuse and what to look out for. For example, if they are overly sensitive about something. That would make me question why"; "We need to make sure we do not do anything that puts people at risk"; "If I see any bruising for example, I will call the office immediately. If I saw they had a fall, I would check the book in the person's home to ensure it had been all recorded"; "I listen to people to make sure they are safe from abuse. I would look out for bruising for example. Any concerns, I would call the office" and "It is about dealing with a lot of vulnerable people who may feel endangered by someone".

All staff we spoke with told us they would be happy to report anything of concern to their manager, the local authority, the police or the Care Quality Commission. We saw where safeguarding concerns had been identified, these were reported to the local authority and details were recorded. This was confirmed by the local authority and we checked our records which also confirmed this. However, during our inspection one person told us that they had to sometimes administer their own medication as staff did not always turn up in time. We alerted the registered manager and deputy manager. They arranged for this person to have a review of their call times. We also reported this to the local authority who investigated these concerns.

Staff were happy to whistle blow and knew who they could inform if they had concerns. Whistleblowing is where someone can anonymously raise concerns about standards of care. They said "I am happy to do this and it is really necessary" and "I would not hesitate to whistle blow, I would go to the local authority".

Some people allowed staff to do shopping on their behalf. We saw records of cash transactions were maintained in people's homes. Records were maintained of the amount spent, receipts were obtained and these were regularly checked by an office staff member for accuracy. We also saw the client signed to confirm receipt of their purchase.

Staff were aware of the importance of people's safety in their homes. They said, "I would look out for risks in people's homes. For example, rugs they could trip on, open fires"; "I recognised one person who was self-neglecting themselves. I contacted the office and it was referred to the safeguarding team at the local authority"; "I will look for risks to people, cables on the floor or other hazards" and "I will ensure there is no

furniture in their way so they don't trip. Look for other objects as well, for example, equipment. I always ensure the house is secure when I leave and no appliances are left on".

We looked at people's records in the office and saw risks to people were managed and reviewed. Where people were identified as being at risk, assessments were in place and action had been taken to manage the risks. For example, if people had specific health conditions or had impaired eye sight. These were clearly recorded and the risk to the person assessed in their care plan.

We saw systems were in place to monitor accidents and incidents and staff were notified of any incidents regarding the people they looked after. Details were fully recorded including action taken following the incident and changes made to keep people safe where possible.

People were mainly supported by their family member to take their medicine or self-medicated themselves. Those who received assistance with their medication told us they had their medication when they needed it. People said; "They press the tables from a box and they give them to me"; "They put it in a pot and I take it myself"; "I get my medication when I need it and they help me with it. Staff always remember to give me my medicine" and "They help to get the medication out of the locked cupboard. They make me a drink and give me my medicine in a little pot". Staff were aware of the national practices when administering people's medicine. For example, one said, "If there is no blister pack and the medicine is in boxes, I will use a spoon or a cup to give the medicine". When we visited people's homes, we saw on two occasions the medication administration record (MAR) had not been completed for the administration of topical creams. One was on the day of our visit on 15 September 2017. The other was where the records had not been completed on five occasions in September 2017. We discussed this with the deputy manager who agreed to address these errors and take up with the individual staff member. The missed medicine did not require the GP to be notified and people did not come to any significant harm.

Care workers knew how to keep people safe from cross contamination. People told us care workers always wore protective gloves and aprons when providing personal care. They also said these were disposed of once the task had been completed.

Requires Improvement

# Is the service effective?

## Our findings

People were not always confident staff had the training and skills they needed to care for them. They told us, "I had one new care worker who told me - I am not sure what I am supposed to do"; "No, I don't think so. They can be touchy feely, which I can't stand. Hand on the shoulder, rubbing back, rubbing shoulder. I have not said anything to the staff, but I feel when it's reported to the office it goes in one ear and they still send them around"; "Yes I suppose they know what they are doing. No one is completely useless"; "I have difficulty with one of the care workers as they struggle to understand English, they did not know what a salad was!" and "Not always, temporary care workers don't seem to. I take it up with the care workers as and when it happens".

However, others were happy with care worker competence. Comments included, "Most of them (care workers) know what they are doing and I feel safe with them"; "I think so. They seem to know what they are doing. I look forward to them coming"; "Yes I think they do (have the training)"; "Most of them have the training" and "Yes I do, especially my normal regular care worker".

People told us they were not always aware of which care worker would be arriving or that they were introduced to a new care worker. People told us, "I have only had one who was introduced. They generally introduce themselves. I have not had too many different ones"; "He was not really introduced, they just arrive"; "They usually just turn up"; "They knock on the door and come in and say 'it's your carer'. I don't even know their names sometimes. They don't say their names"; "A lot of staff changes, there was a new care worker and they did not know my routine" and "They just come in. I don't like that. I would like the same care worker all the time. A lady came today and I didn't know who she was. She was a very nice lady though". This meant there was poor communication between people in receipt of the service and office.

We saw the training matrix for care workers. It showed all staff had received training, for example, safeguarding, medication, food handling, infection control and food safety. Staff comments about their training included, "I have done medication administration. This included the completion of MAR's. I have had a refresher course and I am now very confident when administering medicines"; "I have found my training to be good and very useful"; "Yes I think the training is sufficient and mine is up to date"; "When I had my training, my competency was checked to make sure I was competent"; "I had enough training to do the job. I had four days when I joined the company" and "The training is regular. They call us when refresher training is due".

Although staff told us they had received enough training, some felt their own safety was compromised at times and further training was needed. One said, "There is one person who needs two strong people to move them, but they keep sending me and it's hurting my back. We have had theory training on how to use hoists. This was on the last day of my induction, but I don't feel there was enough training for me and need some practical training". Another staff member said "I have not had dementia training. It was a bit of a shock when I went in to look after [client name]. I was not sure how to handle this person".

We recommend staff training needs are reviewed and effective communication is maintained when people

receive care from a new staff member.

Staff commented about their induction, "We do about 40 hours of shadowing with another care worker, so it's good"; "The care worker I shadowed was very good, it was really useful to learn on the job"; "I shadowed for one evening only, but that was fine as I always work with another care worker" and "I had a lot of training as part of my induction. This was broken down in a booklet and it covered each section we did on a daily basis. We would then discuss the training as a group the following day. It was really informative and prepared you as much as you can before you go out to people. We could query anything and raise further questions. The induction and training was not rushed".

Records showed staff received regular supervision. Supervision is a one to one meeting with their line manager. Supervisions and appraisals were scheduled throughout the year. Staff were able to raise issues and make suggestions at supervision meetings. We saw staff had face to face supervisions, telephone supervisions and, in most cases an annual appraisal. We spoke with staff about the support they received. Comments included; "I feel supported, the staff are nice"; "I have regular supervisions with [name]. I can discuss anything, it's an open conversation and I can raise things. In between this I can call my supervisor, ask anything. If any problems, without a doubt I can get support"; "The support is fine"; "I can talk to them (supervisor) if any problems"; "I have had formal supervision with my supervisor. I can raise things and feel I am listened to" and "I am well supported by my supervisor, I am given optional dates for our discussions".

In the staff files we viewed we saw staff competencies were checked and where further training needs were identified, this was recorded as part of their 'record of instruction' and followed up at the next supervision.

Staff we spoke with had a good understanding of the Mental Capacity Act (MCA) 2005. The MCA is the legal framework to ensure people's right to make decisions for themselves was adhered to. We also observed references to capacity in people's support files regarding supporting their choices. This included a mental capacity assessment where appropriate for people. Staff said, "It is whether the person is capable to make decisions about their choices"; "It's if they can make their own decisions or not and if someone will have to do that for them"; "We should treat people the same, whether they can make a decision or not. People may make different decisions, some we may not agree with"; "People may struggle to make decisions and we are here to help them to make those decision" and "It is recognising people may have difficulty in make a decision and helping them to do this".

People who were supported with their meals told us they were happy with how they were prepared. People's comments included, "It's nice to have them help me with my food and it's nice because the care worker is interested in cooking"; "They will make me a Horlicks at night"; "They get my breakfast. A cup of coffee and crisp bread with Philadelphia cheese" and "They ask me what I would like for my lunch and I usually have a ham sandwich and they make it for me". Staff told us, "If I do cook for people, I always ensure I give them a choice of what they would like and I check food is in date".

People were supported to have access to health professionals. One relative told us, "They took him to have his cataracts done and brought him home. Because I am housebound, they do take him to the hospital when he needs eye tests". Staff told us they would contact the GP for people or call the office, who would arrange this. We saw details were recorded in people's care plans when calls were arranged.

Good

# Is the service caring?

## Our findings

People who use the service and relatives gave us many examples of how care workers were caring towards them. People told us care workers are always friendly, considerate, polite and try to be helpful. Comments included "I have no concerns with the way care workers treat me. They are very polite and very nice. I seem to get on well with them"; "They are fine. We get on alright"; "They are friendly. They are just nice. They ask 'is there anything else you want' and they get it for me"; "I ask for her because she does everything I want doing. She's become a friend now and she's very caring"; "They care for me with a smile"; "They are always polite and we have a very good relationship"; "Our friendship has developed. They know what I like and my tastes"; "Care workers I find are very helpful"; "So far the care workers are very good"; "All of them (care workers) are marvellous" and "Always friendly and helpful".

One professional commented, "The staff are exceptionally good. Care workers talk nicely to people and are really nice and do a sterling job".

We saw staff demonstrated a caring attitude toward the people they assisted. Staff told us, "I love the work. I build up nice relationships with people. I see them regularly and I enjoy going to them and most of them are appreciative. It keeps me going knowing that people appreciate my support"; "I find my job very rewarding. It's lovely to have good relationships and it builds trust between us and the person. I have had good feedback about my work and this is very rewarding"; "I feel I am a good care worker as I am kind and considerate"; "I love the job and people, that's why I do it"; "I get on very well with people. I love what I am doing and I get on with all of them (people). I am a good care worker as I am compassionate and treat everyone like they are my relative"; "To work with people, who appreciate it, is lovely, it makes the job for me" and "I feel I am good at my job and I make people laugh".

People and their relatives told us they felt involved in decisions about their care. We saw one person was unable to sign consent to their care. The care plan was annotated with 'I explained the information verbally to [name], [name] was happy with this and signed on their behalf". People said "Yes, I am involved in my care planning. For example, what help I need and what food I like"; "They always ask me what I want"; "I direct all my care and I have agreed my care plan"
Relative's comments included, "They chat to him, try to involve him in conversation and asks what he wants. They get to know his little ways and make him feel safe" and "Yes the do involve him in decisions. They ask him where he wants his walking frame put".

People told us they had a choice of whether they wanted a male or female care worker. Where possible, people's choice was met.

People's consent was obtained before providing personal care. This included consent to share information with professionals. We saw this was documented in people's care records.

Staff told us they respected people's choices. Comments included, "Choice is important as everyone is different. Its personal choice and I get to know what people want"; "I always ask for consent before I assist

anyone"; "I always ask for consent. For example, offer a shower and ask if it is ok" and "I always give choice as much as possible to people. Whether it be what clothes they want to wear or if they want to watch the television".

People's dignity and respect was upheld. People told us "Yes, when I have a shower they are brilliant. They help me with dignity as I cannot get over to wash one side of my body"; "I have a full body wash and I tell them to leave the bathroom door open and they go downstairs. They let me have a soak for a while, then wash and dry me"; "Yes they do promote dignity. They close the doors and knock on the door"; "I have a walk in shower and so we go in and shut the door. I have a towel and we go into the bedroom where she puts cream on my skin and puts my nighty on"; "they will help me to be as independent as possible"; "Some care workers help me to be independent"; "Staff talk to me really nicely"; "They show me respect and always talk to me when using the hoist and tell me what they are doing"; "They always protect my dignity when I am in the hoist, my wheelchair or the commode" and "I wash with my right arm and do my left side. They do the other side and they encourage me to do as much as I can". One relative said; "They greet him in the morning, say goodbye and shake his hand".

Staff told us, "I respect people. If they become upset I will calm them down. To us it may be nothing, but to them it's very important"; "I always ask and respect their choice"; "I always close curtains and doors. I keep the top half of their body covered if I am washing the lower part. I make sure they feel comfortable"; "I ensure people's confidentiality is maintained. I know you should not divulge any information about anyone and do not give any details out about a person"; "I do not talk about people to anyone" and "I make sure I leave people to their privacy if they are using the commode. I always respect people's wishes".

People were supported to access advocacy support. For example, we saw one person whose safety had been identified as an issue. A best interest meeting had taken place with the advocacy service and health professionals to agree how to keep this person safe. Another person had been referred to the advocacy service and the Court of Protection to ensure the right support was in place to manage this person's behaviours.

Requires Improvement

# Is the service responsive?

## Our findings

The care plans held in people's homes did not contain the same information as the copy held in the office. The care plans were incomplete with documentation about the person, their care needs and risks associated with these. Of the care plans we viewed in people's homes, there was no evidence these care plans had been reviewed. They were disorganised which made it difficult for care workers to obtain information about the persons care needs. In one person's home there was no care plan in place. At weekends we were told that agency staff cared for people. Staff told us they used the care plan to obtain details of the care needs of people if other information was not available. People told us that there were occasions when care workers did not know what care they needed and they had to tell the care worker what their agreed care was.

People commented, "I usually go through it (what I need) if it's a new care worker"; "They do write in the care plan, but if it is a new care worker, then I have to explain everything"; "Yes, they write in the book every day. We have a regular care worker now, but on the weekends we have someone else and they read the care plan" and "Some of the new care workers don't bother to look at the care plan. They look at the book, your old assessment, and they go by the book and it's wrong. It (care plan) has not been updated this year". One care worker told us, "No, you don't get the details of the call needs until you get to the house. But sometimes, the other care worker knows. If I am on my own, I usually just get the name and address. I have to look at the care plan when I get to the person's home, which makes me late as the care plans are not up to date sometimes". This meant care workers, including agency staff did not have details available to them to enable to look after people safely.

Although full reviews had not always taken place. We saw daily care records were maintained in all but one case.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and deputy manager recognised some people's care plans had not been reviewed to ensure details were up to date and had a plan in place to review these.

Westminster Homecare Aylesbury took over the care of people from a previous service on 1 April 2016. People who were in receipt of care from the previous provider transferred across to Westminster Homecare Aylesbury on the same date. Therefore a re-assessment of their care needs was not necessary. People who were new to the service from 1 April 2016 were assessed prior to receiving a service to ensure their needs could be met. Meetings were held with people to confirm the support needed. People and their families had been involved in their assessment. Care records contained details of people's personal histories, likes, dislikes and preferences and included the individual health conditions, their, interests and hobbies. For example, the way in which they liked to be supported with their personal care and where nutrition intake was being monitored, this was recorded on a daily basis. People said, "They came out probably several months ago and brought the care plan up to date. Occasionally they pop in at lunchtime and make some

alterations in the plan"; "Yes they came and said what they were going to do and I agreed with everything they said"; "They asked me what help I needed. I did say what I needed" and "Yes, they came from Westminster Homecare Aylesbury last week. They sat down, talking to me about how things were going and what was needed. They are very good". One relative told us, "It was earlier this year then he was assessed to see whether anything had changed". The care files we looked at mainly contained daily logs of the care provided to people. People confirmed staff wrote in these on a daily basis. One person said, "They write in the care plan every time they visit".

In the care plans we viewed in the office, we saw areas of improvement had been identified. We saw the changes needed were noted on the care plan and these changes were checked to confirm these changes had taken place. In most cases we saw a front sheet at the beginning of the care plan which identified critical care needs and risks to people. For example, people's capacity, allergies and a resume of people's care needs. This was in bold large print which made it easy to read. This was a useful document for care workers to use and to provide them with a summary of people's individual care needs.

There were systems in place to record and manage complaints. Records showed complaints had been investigated and people were responded to timely. Details of the complaint, actions taken and the date resolved were recorded. There was an easy read version of the complaints process for people with communication difficulties to enable them to make a complaint. We saw a letter had been sent by the registered manager apologising to the person.

The service ensured, where possible, that people had access to the information they needed in a way they can understand it and were complying with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all provides to ensure people with a disability or sensory loss can access and understand information they are given.

People we spoke with knew how to raise concerns. They told us, "If I had a complaint I would refer to the office. I am aware there is a policy, but not had to use it"; "I just presume you would ring the number in my care book. I have not come to that point though"; "I would go to their head office and speak to someone there"; "I have their telephone number and I can phone them"; "I know who to contact"; "I can get hold of the office if I need to, they are patient"; "One complaint, Saturday evening did not get my care call. But I got a letter of apology from the office" and "I have no complaints. Sometimes I call the managers if the care is not very good. They do listen".
However, we had two other comments from people. "You pick up the phone and you ring. A young lady arrived and she didn't know what she was supposed to do. It was to take me in a car to the dentist. She was not told by the office what my needs were. They should have checked that her car was suitable for a wheelchair. I phoned and put it in writing (my complaint) to them. I didn't receive a letter back. They apologised on the phone. I felt the communication between them and the young lady should have been much greater" and "My daughter is forever on the phone to the office complaining. You talk to the care worker though and they do their best to accommodate you".

Providers are required to comply with the duty of candour regulation. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to registered persons when they are carrying on a regulated activity.

At the time of the inspection, the service had an appropriate duty of candour policy. The document provided clear steps for the management to follow if the duty of candour requirement was triggered. The registered manager demonstrated an understanding of the Duty of Candour.

Requires Improvement

# Is the service well-led?

## Our findings

People and staff we spoke with had varied views about the culture of the service and how it was managed. Comments included; "90% of the care staff don't have a kind word to say about the office. They are fed up by the way they are treated by the office staff"; "I know care workers complain about the lateness of getting their rotas. Some don't receive it until that morning and they have to find out from the office where they have to go". Both of these comments were confirmed when we spoke with care workers. Other comments received from people were; "No, not the office, no I don't think it is well managed"; "On the whole, no. They took over and they didn't realise what a massive job they were taking on. A lot of care workers left and new ones come on board all the time. The care workers are disillusioned"; "It's the office that's the problem. I don't think they are organised properly. I never know when people are coming, who is coming. Sometimes it's agency staff. A rota would help"; "I phoned the office the other day to cancel my visit. This young lad said 'alright, alright' and put the phone down. But the care worker still came the following day, despite me previously cancelling the call"; "I feel staff are constantly under pressure. Communication is so important, especially when they are going to be late. They are constantly under pressure to serve everybody and there's a rapid turnover of staff"; "No care worker has a kind word about them (the office). They say they like the job, and do it for the money, but not for the management" and "The care workers are first class, I can't complaint about the care workers. It's the disorganised office".

Staff comments included; "I don't even realise there is a manager. I have concerns as I feel the communication between the manager and the office staff is poor as concerns don't appear to be passed on"; "The 'on call' person is sometimes difficult to get hold of and they live too far away to help us if needed"; "There is not good leadership or management, a lot of us have commented on the management style"; "Management are ok ish"; "There is no respect for us as care workers from the office"; "Co-ordination of our rota is the problem. I feel that I am pushed into filling the job in your own time"; "We don't get our rota's until the night before, sometimes it's 5pm or 7pm and there is nothing we can do about it"; "The office staff show no respect for us care workers, they used to call us by our surnames! But it has improved a little and we are not treated like robots anymore" and "It's not good to work for them, it's terrible. Office staff do not know what they are doing and they don't always tell us things they should do".

We asked people what improvements they would like. They said, "It all goes back to staffing, I wish I could have a regular care worker – five times a week"; "Be on time, and the same care worker where possible every day"; "A rota would be helpful"; "I would like to receive a weekly rota of which care worker is coming and the times"; "I used to get a rota for a few weeks, but not lately. I like to know who is coming" and "Once a month a telephone call would be nice to ask how we are feeling about things, so we could give some feedback". The majority of people we spoke with by telephone told us they did not get a call from the office to ask if they were happy with their care. The main comment from staff was about the lack of rotas. One commented; "I would like to have my rota at the beginning of the week". The registered manager told us how they were planning to send rotas out in advance and were in the process of employing more staff to manage this.

Staff told us they did not have regular staff meetings. They said; "It's been very busy and not had one lately". We saw there had only been one staff meeting in 2017 which was 22 February 2017. There were 13 staff that

attended the meeting which represented approximately one third of total staff. Staff told us they found it difficult to attend due to their shifts.

We saw communication links to staff. These were by email or a text message to the staff members' mobile telephone. The manager told us, if the staff member does not have a 'smart phone' then they are required to come into the office for updates. However, we were told by one some staff member that they were only allowed to come into the office at an allotted time between 2pm and 4pm. They said this made it difficult to get updates and affected their morale and did not feel valued. Some staff also commented that they received emails which did not affect them, which was not an effective way of communicating. They said "We are not well co-ordinated, communication is terrible. We get frequent last minute changes to our rotas. Frequent changes make it really difficult to ensure people receive a good service". Another care worker said "Communications is sometimes ok, but it's not consistent"

Staff told there was no staff survey to enable staff to provide feedback about the company and what could be done better. The registered manager told us they was an on line option for staff to use, but staff were not aware of this.

This meant that there was not always effective communication available for staff to enable them to raise concerns or to discuss ideas collectively.

We were told by the registered manager and deputy manager that weekly reports were analysed to monitor call times. However, when we looked at the log of calls we found a number of calls were either early or late and very few met the schedule call time. This was not identified by the team and therefore effective systems were not in place to monitor the delivery of service to people. This meant some people received a poor standard of care.

We were told that there was a back log of care plan reviews. Individual tasks had been set for senior staff to review particular elements of people's care plans. For example, medication and daily logs. We were told that there were approximately 30% of care plans which had not been reviewed in the last six months. We discussed this with the registered manager and deputy manager and recommended they set an action plan and prioritise those people who were most at risk. They said they did have an action plan in place and would ensure people were safely prioritised. We asked for a copy of this action plan to be forwarded to us, this was received following our inspection. We saw a target date of 30 October for completion of all care plan reviews. We have asked the registered manager to provide us with an update to confirm these reviews have been completed.

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

There were some positive comments from people and staff. For example, "I am very pleased with Westminster"; "I think it's good now. I like it better because we have a regular care worker. I did feed that back to the agency"; "I am pleased with the quality of care"; "Management are friendly and listen to me. But it does change and I am enjoying this good period at the moment"; "We are happy, very good"; "Westminster are quite good"; "Office are ok to get hold of, quite responsive" and "It's (the service) as good as any".

We saw that a staff newsletter was in place to inform staff of developments. One had been sent to staff in June 2017 and one following our inspection. Details shared included, staff updates and procedure reminders, for example, MAR sheet completion.

Staff said "It's a good place to work overall, I consider this one (service) ok"; "I have no complaints about the job"; "I enjoy my job, it's good"; "We work as a good team, with some of the staff" and "I have had no problems".

The registered manager completed a provider information return on 7 August 2017. In this they told us they were arranging a service user forum at the end of September 2017. They said 'The forum will be used as an information tool for service users and to increase social inclusion'. They felt this would be a good opportunity for people to meet socially and to be given the opportunity to meet the staff at Westminster Homecare. Some people were aware of this event; one said "I have had one (invitation) this week telling me about the coffee morning". Another person said, "I think I had an invitation a couple of weeks back, but I can't get there." They also told us in the PIR they sent out a newsletter to people who used the service every three months. However, some people we spoke with told us they had not received a copy of the newsletter. One person told us, "No, I haven't had anything like that". We discussed this with the deputy manager. They told us the coffee morning formed part of the newsletter and an up to date newsletter would be sent out soon.

The registered manager told us they had arranged a care worker forum in June 2017, however, staff did not attend. They said the next one was planned for the end of September 2017 and were hopeful more staff would participate.

Some people told us they had completed a survey about the care they received. We saw the results of a survey carried out in May 2017. Overall people were happy with the care they received from Westminster Homecare Aylesbury. The survey identified people had raised concerns about the lateness of their scheduled care calls and also that improvements to communication from the office should be made. The Registered manager sent out a letter to people who received a service on 19 September 2017 following our inspection. They had recognised these areas for improvement. They said in the letter, 'This feedback is being addressed through care worker supervisions, regular team meetings, spot checks and through ongoing monitoring' and 'We are working to improve this immediately and I have met with all the office team to go through the survey results'.

We saw audits were carried out by the registered manager and deputy manager. These included staff training. Where gaps in training had been identified, action was taken to arrange further training for staff. A provider quality assurance audit had taken place and an action plan had been put in place to address areas for improvement. At the time of inspection the majority of these actions were 'ongoing'.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>Care plans in people's homes did not contain details of their needs and preferences of care. Regulation 9 (1). |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>There was not effective systems in place to ensure the service operated effectively. Regulation 17 (1) (a) (b) (c) (e). |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staffing numbers and the deployment of care workers did not meet people's care needs. Regulation 18 (1). |