Westminster Homecare Limited

Westminster Homecare Limited (Luton)

Inspection report

Suite 105
Plaza 668
Hitchin Road
Luton
Bedfordshire
LU2 7XH
Tel: 01582 733102
Website: www.luton@whc.uk.com

Date of inspection visit: 12 March 2015
Date of publication: 20/07/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

We carried out this inspection by visiting the office on 12 March 2015. We gave the provider 48 hours' notice that we were going to visit. This was to enable the provider to tell people who used the service and staff that we were visiting, and to make sure that documentation relating to people's care was available for review. Following the office visit, we spoke with people who used the service and the care staff by telephone.

Summary of findings

The service provides care and support to people in their own homes, some of whom may be living with dementia, chronic conditions and physical disabilities. At the time of the inspection, 185 people were being supported by the service.

The service had a registered manager. 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.

Although care plans were detailed and reflected people's individual needs and preferences, they were not always updated when people's needs changed.

Some people's needs were not responded to in a timely way.

Medicines were not managed safely.

There were risk assessments in place that gave guidance to the staff on how risks could be minimised. There were systems in place to safeguard people from the risk of possible harm.

Recruitment processes were not completed effectively to protect people from the risk of being supported by staff who were not suitable.

Staff understood their roles and responsibilities to seek people's consent to care, but did not have a good understanding of the Mental Capacity Act 2005 (MCA).

The staff did not have effective supervision and support, and not all training was up to date.

People were supported by caring and respectful staff. They were supported to access other health and social care services when required.

The service had a process for managing complaints and concerns.

The manager did not have effective quality monitoring processes in place.

People were not routinely asked for their views on the quality of the service and action was not taken to address all issues that were raised.

During this inspection, we found that the provider was in breach of the Health and Social Care Act (regulated activities) Regulations 2014. You can see the action we have asked them to take at the back of the full report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

Staff were not deployed effectively to meet people's individual needs.

Medicines were not managed safely.

Recruitment systems were not used effectively to keep people safe.

Staff understood their responsibilities to report concerns in order to keep people safe.

Requires improvement

Is the service effective?
The service was not always effective.

People's consent was sought before any care or support was provided, but staff did not have a good understanding of the Mental Capacity Act 2005

People's care was not always provided by staff that had been trained and supported to meet their individual needs.

Staff supported people to maintain their nutritional needs where appropriate.

People were supported to access other health and social care services when required.

Requires improvement

Is the service caring?
The service was not always caring.

People were supported by care staff that were kind and caring, but office based staff did not always value people, listen to their views or give them enough information about their care provision.

Care staff understood people's individual needs and they respected their choices.

Care staff respected and protected people's privacy and dignity.

Requires improvement

Is the service responsive?
The service was not always responsive.

People's care plans were not always updated when their needs changed.

People's needs were not responded to in a timely way.

People's complaints were addressed in line with the providers policy.

Requires improvement

Is the service well-led?
The service was not well-led

Inadequate

Summary of findings

Quality monitoring audits were not completed regularly and these were not used effectively to drive improvements.

People who used the service and their relatives were not routinely asked to share their experiences of the service.

Westminster Homecare Limited (Luton)

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection included an announced office visit which took place on 12 March 2015. This inspection was carried out by two inspectors. Following our visit to the office, one inspector spoke with care staff and an expert by expert experience spoke with people who used the service by telephone. 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 provider 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 also reviewed other information we held about the service. This included information we had received from the local authority and the provider since the last inspection, including action plans and notifications of incidents. A notification is information about important events which the provider is required to send us by law.

During the office visit, we spoke with the manager, a senior manager, and administrative staff. We spoke with 15 people who used the service and five of their relatives, and seven care staff by telephone. We also spoke with the commissioners of the service from the local authority.

We looked at the care and medicine records for 12 people who used the service, 10 staff records, and we reviewed the provider's recruitment processes. We also looked at the training records for all the staff employed by the service and information on how the provider assessed and monitored the quality of the service, including reviewing audits and specific policies and procedures.

Requires improvement

Is the service safe?

Our findings

Late calls had a negative impact on some people receiving support to take their medicines as prescribed. One person said, "My evening visits can be anytime from about 7.30pm, but I never know when. I've had girls come in as late as 11.20pm or 11.40pm and wake me up to give me my medication." A relative said, "The times (of visits) are very erratic, especially at weekends, and this can mean medication can be given too close together."

Support plans identified when people were able to and wanted to manage their own medicines or have them administered by a relative rather than care staff. However, we found that the information was not updated when people's needs changed. For example, a support plan identified that one person did not have support with taking their medicines, yet we found a completed medicine administration record (MAR) indicating that staff administered the medicine to the person. A second support plan also showed that a person administered their own medicines, where a MAR clearly demonstrated that staff administered it. The manager confirmed that both people's needs had changed, but their support plans had not yet been amended. This could have resulted in errors in giving the people their medicines.

We checked the MARs for 12 people and found that most had not been completed correctly. We found unexplained gaps in records, where staff had not signed to indicate that they had administered the medicines. There was a code for staff to record when medicines were not taken or refused. However, staff were not using the coding system correctly which meant that the reasons for people not receiving their medicines was not clear. It was therefore unclear if people were always given their medicines as prescribed. A member of staff told us that new MAR charts were not always supplied in time, which meant that accurate records were not always kept. We saw an entry in the daily records for one person which supported this claim by stating, "Gave 1 tablet. No room on MAR chart." There was a system in place for auditing the MAR which were sent up to the office each month after completion. The operational support manager had recently completed an audit of MAR charts which had identified some of the issues we found. However, we noted audits had not been completed regularly. Discrepancies were not consistently identified and action was not always promptly taken to rectify these.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment records for six staff and found that safe recruitment processes had not been completed for four of them. For example, we found unexplained gaps in two employment records, missing references and a Disclosure and Barring Scheme (DBS) check that did not match with the staff member's employment history. DBS helps employers make safer recruitment decisions and prevents unsuitable people from being employed. We saw that one of these staff member's recruitment records had been audited in January 2015, but that audit did not identify the issues we had found. People's safety was put at risk because the service did not use recruitment processes effectively to ensure that they employed suitable staff.

This was a breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of our inspection, the service had 71 care staff that provided support to 185 people. The operational support manager told us that the staff numbers were closely monitored to ensure that they could meet people's needs. However, most of the people we spoke with said that staff were frequently running late, and many commented that there were not enough staff. One person said, "They take on too many clients and not enough staff to do the job." Another person said, "They load the girls with too many calls on their lists. It's not fair on them." Most of the staff said that they were able to manage their workload and that there were enough of them to meet people's needs safely. However, they said that travel time and unexpected delays during an earlier visit sometimes resulted in them being late for their next visit. Other staff told us that the rota did not allow adequate time for travel from one visit to another and that there were not always enough staff available at the busy times of the day to meet people's needs safely.

People told us that they felt safe with their care staff. Relatives told us that they felt confident in their family member's regular staff and that, in knowing the person was safe, they felt able to relax and have a break from their caring role.

Requires improvement

Is the service safe?

The provider had up to date safeguarding and whistleblowing policies and procedures. Staff demonstrated they had a good understanding of safeguarding processes and were able to tell us about other authorities they would report concerns to. One member of staff told us, "I would report concerns to my manager but if she didn't do anything I would inform senior managers or the local authority. I wouldn't just leave it." Although most of the staff also said they were confident that the manager would deal appropriately with any concerns they raised, others were less sure, but said they would escalate their concerns to more senior managers if necessary.

As part of the service's initial assessment process, we saw that an environmental risk assessment had been completed. This helped the staff to identify and minimise any potential risks in the person's home. There were also individual assessments for each person to monitor and give guidance to staff on any specific areas where people were more at risk, such as when people required support to move safely. These explained what action the staff needed to take to protect people from harm whilst promoting their independence. The staff also told us how they ensured risk assessments were adhered to and the importance of this in providing consistently safe care.

Requires improvement

Is the service effective?

Our findings

The majority of people and their relatives spoke highly of their regular care staff and told us they had the right skills to support them. However, this was not always the case when new or replacement staff provided their care, particularly over weekends. One person told us that, although some staff were good, the lack of continuity of staff meant that the quality of care was inconsistent. One person expressed concern that new staff were often not able to deal with their specific condition and that they had to show them how to care for them. They said, "Often they don't even know I have [specific condition] until they arrive, which bothers me. What about those who can't explain it themselves?" Other people also told us that staff sometimes arrived to a visit unaware of their individual support needs, and therefore could not always meet their needs competently. Although some staff referred to people's care records, others needed to be told what to do. Some people felt less confident in their care staff's abilities because of this. This was also confirmed by a relative who told us that, although regular care staff knew their relative's needs well, they "wish all staff could be as proactive."

Staff confirmed that they had received an induction prior to working independently and that this had included shadowing more experienced staff. The service had a computerised system for recording and monitoring staff training. This showed that some training the provider considered essential was out of date. However, the operational support manager told us they had recently recruited a new training officer and we saw that a plan was in place to bring staff training up to date.

Staff had varied views about the level of support they received from their line managers. Some staff said they received support and were comfortable to seek advice from the manager and other office staff if they needed it. In contrast, some staff did not feel so well supported and said that the manager and office staff were sometimes abrupt if approached for support. All staff confirmed that although staff meetings and individual supervision meetings took place, they were not regular. We saw evidence from records that formal supervision took place, although it was not always used constructively to offer staff positive encouragement to develop their skills. We also found that, where performance issues had been noted elsewhere, such as in missed visit logs, this was not identified and addressed in supervision.

These issues were a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People told us that they were asked for their consent before any care or support was provided. The staff understood their roles and responsibilities in relation to ensuring that people consented to their care and support. However, they did not have a good understanding of the requirements of the Mental Capacity Act 2005 (MCA). No staff members were able to confirm that they had received training in the MCA. However, care records showed that people's capacity to make decisions was considered and recorded during the assessment and care planning processes in line with the MCA. The records we looked at showed that some people had signed their care plans to indicate that they agreed with the planned care and the interventions by the staff. Where necessary, people's relatives signed these on their behalf. There was no explanation why other records had not been signed.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people we spoke with did not receive support with meals. Of those who did, most felt that they were supported well with this, although late visits sometimes meant that they did not have their meals in a timely manner. However, one relative told us that, "food is sometimes whipped away because [family member] is slow at eating and they want to clear up, and that's when I'm there, so what happens when I'm not?" Another relative said that their family member's regular care staff understood their needs and encouraged them to eat. However, other care staff did not know how to do this successfully. This meant that their family member would not eat much on those days and as a consequence, had lost weight. Staff told us that, if they had concerns about a person losing weight, they may discuss this with the person's relative, or with senior staff to ensure a referral was made to their GP or to a dietician as appropriate.

Requires improvement

Is the service effective?

People said that they were comfortable to discuss health issues with care staff as they arose and that staff noticed if they were unwell. One person told us how well they had been supported when they needed to go to hospital by ambulance. Staff told us how they worked with other external agencies, such as GPs and district nurses so that people's needs were met appropriately. Care records showed that, where necessary, other health and social care professionals were involved in people's care. For example, daily records showed that a care staff had contacted a district nurse with concerns about the risk of a person developing pressure damage to their skin. Some people had social workers who reviewed their care to ensure that their needs were being met.

Requires improvement

Is the service caring?

Our findings

Although people spoke highly of the care staff, many people were dissatisfied with the way in which they were treated by some staff who were based at the office. For example, one relative told us, "One of the [office based staff] doesn't seem to listen. The annoying thing is you can tell by their attitude that they're not really bothered."

People told us that the care staff were friendly, caring and kind. One person told us, "[Member of care staff] is more than a carer to us, she has become a friend." They went on to explain that the member of staff always checked if they needed anything else before they left, and always did more than was required of them. Another person said that their staff were "wonderful girls" and a third person said that staff "never come in grumpy, always with a smile". A relative said staff were "very good, they're like friends to my mum." People said that the staff chatted with them while they supported them even though some commented that staff did not have much time. The staff were happy with how they supported people, but they said that the constraints of their work meant that they were not able to spend more time with people. One member of staff told us, "If you stay over your time with someone, it makes you late for the next person. So there's not really time to chat."

People said that they could express their views and were involved in making decisions about their care and support on a day to day basis. They told us that they had been involved in developing their care plans and the staff supported them in line with their individual choices and preferences. The care records contained information about people's needs and preferences, so the staff had clear guidance about what was important to people and how they liked to be supported. People told us that the regular staff understood their needs well and provided support in the way they preferred. People told us that staff were flexible in their approach to providing care. One relative told us that care staff were patient, calm and respectful towards their family member and supported them well when they became anxious or distressed by distracting them or changing the order in which they offered care. This showed that the approach to care was focused on the person receiving support rather than on completing the task.

People told us that the staff respected their dignity and privacy. Staff also demonstrated that they understood the importance of respecting people's dignity, privacy and independence. One staff member described how it was important for people to do as much as they could independently, and pace the assistance given to meet people's individual needs. Another member of staff spoke about dignified care and making sure that people's privacy was maintained, for example, by keeping them mainly covered when assisting them to wash.

Requires improvement

Is the service responsive?

Our findings

Each person's care records contained referral paperwork from the local authority. This information was used as a starting point for the service to conduct their own assessment involving people and those that mattered to them in order to develop a personalised support plan. Plans were detailed and provided information on how people liked their care to be delivered. People and their relatives said they had contributed to the planning of their care and the staff confirmed that each person they supported had a care file in their homes. However, the care records we looked at for one person did not contain a support plan, although daily records indicated that the person had been receiving support since September 2014. The manager told us that a care plan had been hand written for the person and would be held at their home, but that a typed copy had not yet been put in the person's records at the office. This meant that information may not have been available to staff before they provided care to the person. However, staff told us that information about people's care needs was usually available before care was provided and they felt they had enough information to support people appropriately on most occasions. We found that some people's care plans were not reviewed or updated when their needs changed. This put people at risk of not receiving care that was appropriate to their current needs.

People told us that they preferred to be supported by a consistent group of staff but this did not always happen. They said that they did not always receive information about when a care worker would be visiting them or which one was coming. One person said, "I never know who is coming. I'm getting used to that." Another person said, "I never have a rota, I never know who or when someone will come. It would really help me if I knew in advance." Many people told us that the communication from the office was poor and that they rarely received a call to inform them if a care worker was running late or not coming. People felt this impacted on how they chose to spend their day. One person said that they never felt able to watch their favourite television programmes if the staff had not come on time as they were "invariably disturbed."

Although the management team aimed to ensure that people were supported by regular staff, staff that people did not know were used to cover absences and staff days off. Most people understood that this was sometimes unavoidable, but felt that the changes in staff were too frequent. One person said they had kept a record showing they had received care from 56 different members of staff since 2012. This put people at risk of receiving inappropriate care because the frequent changes in staff meant they were supported by staff who did not know them well.

Most people said that their individual needs were met well when they were supported by their regular care staff, but that this was not always the case when supported by new or replacement staff. One relative told us how valuable the service was to them and their family member as it gave them respite from caring and the opportunity to relax while they were out as they knew their family member was being well cared for. In contrast, some people told us that the care provided did not always meet their individual needs. One relative said, "It's the little things that get left. They don't ever clean the bathroom if [family member] has an accident. They leave it to me, but what happens to those with no families?" Another relative told us they had witnessed staff not supporting their family member appropriately with personal care. They said, "If I had not come upstairs at that moment, they would have dressed [family member] without cleaning their bottom first. Once I came up, they put the clothes down and washed them first."

The main concern raised by most people was that their visits were often late. One relative said that visit times varied by up to two hours, and told us about the distress this caused their family member. They said, "[Name] keeps telling me to ring to find out where they are. I try to put it off for as long as I can. I know they will always come, but eventually I give in and ring the office. It would be so much easier for us both if they came on time." Other people also commented that they were not happy with the timings of visits, including the morning visit being either too early or too late, or visits being too close together. One relative told us that their family member had support in the mornings so that the relative could go out, but care staff sometimes arrived much earlier than expected, when neither the person or the relative were ready. They said, "It's a big issue. The girls understand and apologise, but the management still send them, they're just not efficient. Sometimes I send them away."

Requires improvement

Is the service responsive?

These issues were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although people told us they felt comfortable to raise concerns, some people expressed the view that the office staff did not respond to calls or take action when concerns were raised. However, other people told us that action was taken when they complained. For example, one person told us that they had told the office staff when they were unhappy with a particular staff member. They took action and the particular care worker was not scheduled to work with the person again. The provider had a complaints procedure which was included in the information pack given to people at the start of their care package. There was a system in place to record all complaints received and these had been investigated in line with the provider's complaints policy.

Inadequate

Is the service well-led?

Our findings

A registered manager was in post. Although the registered manager was present for our inspection, we did not find that she demonstrated good visible leadership during our visit. The provider had also arranged for the operational support manager to be based at the service to provide ongoing support to the registered manager. The operational support manager provided most of the information and answers to our queries during the inspection.

Most people felt that the service was not well managed and that staff did not receive good support. Most, but not all staff, told us that the support from their manager was sufficient and that they found her approachable. In contrast, other staff felt that they did not receive good support. Many people told us that communication from the office staff was poor and that the service was not well organised, with punctuality being a particular problem. The comments people made to us about this were reflected by the feedback given by people to the service and were also confirmed by the visit logs we reviewed. The manager did not promote an 'open culture', where people or their relatives felt comfortable to speak with them whenever they needed to and some people said that their calls were not always promptly returned when they left a message with the office staff. Other people said that they were never informed if there were changes to the staff allocations.

Staff told us that office staff monitored care staff's visits to support people through a computerised log in system, which triggered an alert if a staff member was more than 15 minutes late. However, there was no evidence that these alerts were looked at or that any action was taken. For example, a care worker who was due to arrive to support one person at 8.45 logged in two and a half hours late at 11.15. There was no evidence in the logs that they had rung in to say they were running late or that the person waiting for support was advised that the visit would be late. The manager told us that they checked the logs regularly, but there was no evidence to show what action they had taken when alerts came in.

We were told that the manager and team leaders completed regular spot checks on staff and that these could be located on their files. Having seen none in the files we looked at, we checked a further six files and could find no record of spot checks having been completed on the quality of care provided. We were shown a folder which contained 13 spot checks all completed in a two week period in December 2014. Apart from this folder, the manager was unable to provide any evidence that she monitored the quality of the care provided by staff. Minutes of a recent senior staff meeting stated that locating staff was sometimes difficult as staff did not always complete their visits in the order planned on the rota. This made it difficult for senior staff to complete spot checks. No staff we spoke with were able to confirm that they had had a spot check in the last 12 months.

People told us they did not have regular contact with the office and that management staff rarely, and in some instances, never visited them at home. One person told us that they were very happy to discuss their care with us and they wished that the service's managers would review their service in a similar way. The manager told us that telephone interviews and home quality visits were undertaken to seek feedback from people who used the service and their relatives. However, we only found records of a telephone visit or a home quality check in three out of the twelve care records we looked at. There was a system in place to monitor that home quality checks and telephone monitoring interviews took place regularly. However, these records showed that many calls and visits were late or had not been completed. The service had recently carried out a satisfaction survey and had received responses from 51 people. However, some people told us that they did not fill them in for a variety of reasons. One person told us that they would prefer to speak with someone, as they were not able to see well to read and write. They had not had the opportunity to speak with anyone by telephone. Another person said, "Nothing changes anyway. We never get feedback on what people have said, so what's the point of them?"

The provider carried out an annual quality audit visit which covered all aspects of the service and identified areas where action was needed to meet the required standards. However, the manager was unable to evidence that an action plan had been developed from this report. She told us that there had been one, but it had been archived because all actions were completed. However, we found that several issues identified during the last quality audit were still outstanding. A recent local authority audit had also raised similar concerns. An action plan in response to the local authority report had been developed and was regularly updated with progress reports by the operational

Inadequate

Is the service well-led?

support manager. The provider also had a range of service based quality audit systems, such as medication administration records (MAR) and care plan audits. However, the manager was unable to provide evidence that these were regularly completed and in many instances, we saw that records on file had been left blank. Although systems to monitor people's health, welfare and safety were in place they were not used effectively. For example, the provider had a computerised system to record and monitor incidents and accidents. However, when asked, the manager was unable to demonstrate how they used this system to monitor for patterns and trends. They said that they recognise if a person is at a higher risk if they "hear the person's name coming up more often in conversation in the office." This did not demonstrate that the manager recognised their responsibility for monitoring and promoting the welfare of people who used the service.

All of these issues were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 The provider assessed and planned person centred care, but the delivery of care did not meet people's needs or reflect their preferences. Regulation 9 (1) (3) (b) and (g)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated the management of medicines. Regulation 12 (g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems to monitor the quality of the service were not used effectively and up to date,accurate records were not kept. Regulation 17 (1)(2)(a)(b)(c)(d) Feedback from relevant persons was not sought or acted on to improve the service. Regulation 17 (e) and (f)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff did not always receive appropriate support, training or supervision to enable them to carry out their duties. Regulation 18 (2) (a)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The recruitment procedures were not operated effectively to ensure people were protected from the risk of being cared for by unsuitable staff. Regulation 19 (1), (2) and (3)

This section is primarily information for the provider

Enforcement actions

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