Notaro Homecare Ltd

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We undertook this announced focused inspection on the 16 January 2018 of Notaro Homecare.

This inspection was to check that improvements had been made to meet legal requirements after our unannounced focused inspection of this service on 18 and 28 September 2017.

At the November 2017 inspection we found a breach of legal requirements due to people not receiving their medicines safely. After the focused inspection, we used our enforcement powers and served a Warning Notice on the 8 November 2017. This required that the provider had to meet one legal requirement relating to medicines management by 20 November 2017.

This report only covers our findings in relation to this requirement. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Notaro Homecare Ltd on our website at www.cqc.org.uk

At this focused inspection the members of the CQC medicines team inspected the service against one of the five questions we ask about services: is the service Safe.

Notaro Homecare is a domiciliary care agency. It provides personal care to people living in their own houses in the community. At the time of the inspection the agency was supporting approximately 250 people who received personal care in their own home.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection we found a breach of legal requirements as people's care plans, risk assessments and medicines administration charts were not always complete and accurate to reflect people's support needs.

At this inspection we found action had been taken to improve the management of medicines in the service and we were satisfied that the requirements of the Warning Notice had been met. We have made one recommendation relating to the sustainability of these improvements through regular policy review.

We found action was taken following shortfalls found in medicines audits undertaken in the service. When members of staff had not completed accurate records the provider had identified the shortfalls and placed the care staff on a training programme.

The provider carried out an assessment of competence for all new members of care staff so that all new members of staff were competent at administering medicines.

The provider's medicines policies and procedures were not always up to date and required a review following actions identified on the action plan.

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.

We found action had been taken to improve the management of medicines in the service.

The provider had developed an action plan which they need to continue to implement.

Medication care plans for people did not always contain sufficient information for care workers to administer medicines safely and consistently.

Current Medication Administration Records were completed fully and showed that people received their medicines as prescribed.

Notaro Homecare Ltd

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.

We undertook this announced focused inspection of Notaro Homecare on 16 January 2018.

This inspection was done to check that improvements to meet legal requirements after our focused inspection on 18 and 28 September 2017 had been made. We inspected the service against one of the five questions we ask about services: is the service Safe. This is because the service was not meeting some legal requirements.

We gave the service 48 hours' notice of the inspection visit because it is small and the registered manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

Before the inspection we reviewed the information we held about the service. We looked at the information we had received including their action plan following the last inspection which detailed the improvements they intended to make.

The inspection was undertaken by two members of the CQC medicines team. During our inspection we spoke with the registered manager, the provider's Nominated Individual, three people using the service and two relatives.

We looked at the Medication Administration Records and associated care plans and daily records for 16 people and we visited four people who were in receipt of the medicines support. We also gained views from two relatives.

We also looked at other records relating to medicines audits and the providers action plan for delivering safe medicines administration. This included risk assessments, staff training documents and medicines training plans.

Requires Improvement

Is the service safe?

Our findings

At the last inspection of this service on the 18 and 28 September 2018 we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014). This was due to people not receiving their medicines as required as people were experiencing missed care visits or late visits. We found due to people not having their visits when required meant they were not receiving creams, eye drops or tablets as they had been prescribed. We also found care plans did not always contain up to date and accurate information relating to people's personal care, incontinence needs, skin care and diabetes.

At this latest inspection we found action had been taken to improve the management of medicines in the service. We found Medication Administration Record (MAR) charts care plans and daily records relating to 16 people had up to date information recorded. People's MARs charts had improved and people were receiving their medicines as prescribed. The provider had completed an audit of completed MAR charts for December. The audit had identified where shortfalls had occurred. The provider had an action plan following the audit. Actions included the introduction of new MAR charts as the previous charts did not include all recommended information. Another action included identifying staff as requiring additional training to ensure they were administering medicines accurately.

On reviewing 12 people's MAR charts from December 2017 we found not all medicines had been recorded as administered when required. For example, we found some medicines had been recorded in the persons daily care records. We found the person's medication care plan for some people did not contain all the information for care staff to have detailed guidance of what the person required administering and when. We reviewed four people's current MAR charts in use and found one gap in recording administration. All other records were complete and up to date. People confirmed they had received their medicines as required. This meant although records confirmed people had received their prescribed medicines as required in January records were not always being accurately completed.

Systems had improved to identify shortfalls relating to the safe administration of medicines. For example, When staff had not completed accurate MARs records the provider had identified the shortfalls including what care staff required refresher training in the safe administration of medicines. The provider had also carried out an assessment of competence for all new members of staff administering medicines. Not all records confirmed this.

We recommend that the provider continue to review their medicines policies and procedures and ensure these are up to date, current and reflect published guidance.