Sevacare (UK) Limited

Mayfair Homecare - Westminster

Inspection report

Suite 20, Redan House
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31 July 2017

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an announced comprehensive inspection of this location in January 2017. We found a breach of regulations in relation to safe care and treatment. We also made recommendations about how the provider monitors the punctuality of staff and the management of medicines. After this inspection the provider wrote to us to say what they would do to meet legal requirements in relation to the breach of regulations.

We undertook this announced inspection on 27 and 31 July 2017 to check whether the provider had followed their action plan and now met legal requirements. This report only covers our findings in relation to these areas. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Mayfair Homecare – Westminster on our website at www.cqc.org.uk.

'Mayfair Homecare – Westminster' is a domiciliary care agency formerly known as 'Sevacare – Wesminster'. The agency provides support to older people, people with physical disabilities and people with mental health conditions in the London Borough of Camden and the City of Westminster. At the time of our inspection there were 78 people using the service.

The location 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.

We found that the provider now met regulations in terms of how they assessed and managed risks. However, we found that the provider was not meeting this regulation with regards to the safe management of medicines. The provider had acted on our recommendation with regards to monitoring the punctuality of care workers.

Since our last inspection the provider had followed their action plan, which involved providing additional training to assessors on how they managed risks and reviewing existing risk assessments and management plans to ensure they accurately addressed people's needs. This included measures such as assessing people's homes for safety, checking that equipment used for moving and handling was safe to use and providing information to staff on risks to people from diagnosed health conditions such as diabetes and dementia.

At our last inspection we made a recommendation about how the provider monitored the punctuality and attendance of care workers, as there was some evidence of late calls and a lack of systems to monitor this. At this inspection we found the provider was implementing a call monitoring system which was now in use for the majority of people who used the service. This showed that most care workers now arrived on time.

At our last inspection we also made a recommendation about how the provider checked that records

relating to medicines were up to date. At this inspection we found that medicines were not always safely managed. This was because there was often inconsistency between how medicines administration recording (MAR) charts were completed by care workers and in some cases there were gaps in these records which were not suitably addressed by audits. Some MAR charts did not contain clear administration instructions for care workers to follow and sometimes care plans and risk assessments did not accurately reflect the support people received.

We found one breach of regulations relating to the safe management of medicines. You can see what action we told the provider to take at the back of the full version of this 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 provider had taken action to improve the safety of the service in relation to assessing risks to people's safety and wellbeing. However, medicines were not always safely managed by care workers.

Staff punctuality was good in the majority of cases and there were systems in place to monitor this.

We were unable to change the rating from "requires improvement" as the provider was not meeting regulations with regards to the management of medicines. We will look at this again at our next comprehensive inspection.

Mayfair Homecare - Westminster

Detailed findings

Background to this inspection

We undertook an announced focused inspection of Mayfair Homecare – Westminster on 27 and 31 July 2017. This was done to check that improvements to meet legal requirements planned by the provider after our inspection in January 2017 had been carried out. 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.

Prior to the inspection we reviewed records we held about the service, including information about significant events the provider had informed us about and the provider's action plan from their previous inspection. We spoke with a contract monitoring officer from a local authority. The inspection was carried out by a single inspector on both days and was supported by a specialist professional advisor in medicines on the first day. An expert by experience made calls to 16 people who used the service and four relatives. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We looked at records of care and support relating to 16 people who used the service and of records relating to the management of medicines for 10 people. We also reviewed incident reports and records relating to the use of the provider's electronic call monitoring (ECM) system. We spoke with the registered manager, area manager, care services director and two senior care workers.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in January 2017 we found that risks to people who were using the service were not always safely assessed and managed. This was because many risk management plans were generic and contained information which was not relevant to the individual, such as incorrectly stating that people had dementia, diabetes or had oxygen in their premises. Many plans stated that care workers carried thermometers and checked water temperatures when bathing people even though this was not the case. Sometimes the provider had not ensured that equipment used by the provider for moving and handling was safe to use and the provider did not always assess risks to people from long term health conditions.

As this inspection, we found that the provider was now meeting this regulation with regards to risk assessments. The provider told us that they had improved risk management training to assessors. Most risk assessments had now been reviewed, although we found one which still required review. We saw that the provider had included information on when people had health conditions such as diabetes or dementia. Although this information was sometimes generic it contained advice for care workers on how this condition may affect the person's wellbeing. There were also simple management plans in place, for example for a person living with diabetes, there was information on how staff could minimise sugar intake, provide balanced meals and also guidance on possible signs the person was becoming unwell and which actions to take.

There was also information on people's risk management plans on actions for staff to take if the person displayed behaviour which may challenge. The provider had also introduced a detailed falls risk assessment. This included identifying possible risk factors such as a history of falling, certain health conditions, taking more than four medicines and being unable to rise from a chair. It also provided clear instructions for the assessor to check for postural hypotension, a condition which may result in faints or falls. The assessment was used to identify the overall level of risk and to instruct staff to make appropriate referrals to medical professionals if a high level of risk was identified. The provider told us that they had carried out falls prevention training with the local authority and showed us a falls reduction leaflet they supplied to people who may be at risk.

We saw that when care workers were required to use equipment such as hoists, assessors had checked that these had been serviced to ensure that they were safe to use and this was checked by managers as part of the audit process. We also saw that assessors made checks of the person's living environment to assess its safety, including checking that a working smoke alarm was in place. In one file we looked at, the assessor had noted that the person did not have a smoke alarm, and had taken appropriate measures to ensure that this was arranged.

People who used the service told us that they felt care workers tried to help them to keep safe. Comments from people included "They are very careful about that", "They check, they are aware there are a lot of things that are going to be dangerous" and "They check every time, health and safety they call it."

At our previous inspection in January 2017, we made a recommendation about how the provider monitored

the punctuality of care workers. This was because some calls were late, and the provider did not have systems in place to follow this up, and the local authority had some concerns about the punctuality of care visits.

At this inspection we found that the provider had acted on this recommendation, and was in the process of implementing an electronic call monitoring (ECM) system which required care workers to log in on arrival at people's houses. We found that around 70% of people now used the system, and the provider told us they were working to improve this number. This meant that the provider was now able to more accurately measure the punctuality of workers, and for a week in July the system showed that 87% of calls to people who used call monitoring were within 15 minutes of the planned visit time. The provider said that a number of serious incidents in the local area had also affected punctuality. The majority of people we spoke with were satisfied with the punctuality of their care workers, although three people still had concerns. We spoke to a monitoring officer in the local authority, who told us they now had no concerns about the provider's punctuality.

At our last inspection in January 2017 we made a recommendation about how the provider ensures that there is accurate information on care plans and risk management plans about people's medicines. We found that there had not been improvements in this area of care.

People we spoke with told us they received medicines safely when care workers provided them with support. Comments included "I'm on tablets, my carer gives them to me" and "Yes, they remind me."

The provider told us that the local authority had not commissioned a pharmacy service in order to support them with giving medicines, which meant that pharmacies were not able to supply them with a printed medicines administration recording (MAR) chart. The provider was therefore producing its own MAR charts, which were compiled using information from medicines labels. However, this meant that sometimes key information such as warning labels and dispensing instructions were not added to these charts, although staff would still be able to access this from looking at medicines labels.

In addition, the provider operated two different MAR chart formats, between which certain codes had different meanings, and this meant that the use of codes was not always consistent or appropriate. For example, one care worker had used a code to indicate they had seen the person taking a medicine, even though in practice this was for a transdermal patch the care worker had applied, and another care worker had used a code indicating the medicine was taken, even though in practice they had left it out for the person to take later. There was not clear guidance for care workers on how to complete a MAR chart in the provider's policy, and it was not clear what staff should do in the event that a medicines blister pack was only partially administered.

We found some examples where medicines management plans did not give accurate information on the support people received. For example, one person's plan stated that care workers were to administer medicines, but care logs stated that medicines were prompted for. We saw three other examples of this. Another person was using a Minitel device, which is an alarmed pillbox system for reminding a person to take their medicines, although this was in place the risk assessment did not mention this. The same person had a night medicine which was left out for later; care workers had a system in place for checking the next day that this had been taken but we saw there were gaps in the recording. This person also had a pain-relieving medicine added to their chart, but it was not documented that this was a PRN medicine, which is a medicine taken "as needed". The provider's policy stated that PRN medicines required a protocol to be in place, but this was not the case for this person. Another person had an antibiotic added to their chart, without an indication of when the course started or finished. Medicines records were audited by a co-

ordinator or a senior care worker. We saw several examples of discrepancies being followed up, such as gaps on charts which the auditor had followed up and confirmed that visits had been cancelled. However, there were situations where audits did not detect discrepancies. For example, one person's MAR charts had gaps in recording in four consecutive months which had not always been adequately detected or addressed by audits. This was to change a transdermal patch in the morning, but there was a four day period and a six day period when this was not recorded at all, and on one occasion care workers recorded that it had been changed in the afternoon, but this did not appear to have been followed up.

For another person, we noted that they had a medicated shampoo, but MAR charts did not contain clear direction for staff and its use was not always recorded, but at other times it was recorded as being used daily for a month, even though this was not in line with the manufacturer's instructions.

This constituted a breach of Regulation 12 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 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 12 HSCA RA Regulations 2014 Safe care and treatment The provided did not ensure the safe management of medicines 12(2)(g)