

Westminster Homecare Limited

Westminster Homecare Limited (Colchester)

Inspection report

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19 January 2017

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Inspected but not rated

Summary of findings

Overall summary

The inspection took place 19 January 2017 and was announced.

Westminster Homecare is a domiciliary care agency, delivering services in the Colchester and Clacton area of Essex. At the time of our inspection the agency was supporting 121 people.

The service has 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.

Following our last inspection in September 2016 we issued a warning notice because the service had failed to ensure the safe and proper management of medicines and these concerns had been ongoing for some time. The warning notice included a timescale by which compliance with the legal requirements must be made.

We carried out this focused inspection to check that the provider had made improvements. This report only covers our findings in relation to the warning notice and those requirements. You can read the report from our last comprehensive inspection on our website at www.cqc.org.uk

Actions had been taken to improve medicines management. Staff had been provided with clear instructions on when and what they should administer. Advice had been obtained from the pharmacy regarding the administration of specific medicines and there were systems in place to address changes and variable doses. There was a greater awareness of risks regarding medication and care plans outlined the arrangements to reduce the likelihood of harm.

Audits were undertaken by office staff to check that staff were recording correctly and medicines management was explored as part of spot checks undertaken by senior staff. We found that the audits could be further strengthened to safeguard people.

Other issues identified in the September 2016 Inspection under the domain Safe were not followed up at this inspection. We will review our rating for Safe at the next comprehensive inspection. To improve the rating to "Good" would require a track record of sustainability.

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 consistently safe.

Improvements had been made to the administration of medication. Strengthening the audits would provide additional safeguards and offer people greater protection from risk.

Inspected but not rated

Westminster Homecare Limited (Colchester)

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.

The inspection took place on the 19 January 2017. The inspection was announced and we gave the service 48 hours' notice that we would be doing the inspection so that they could make sure the necessary people were available at the office when we called. The inspection team consisted of one inspector.

In advance of our inspection we reviewed the information we held on the service, in particular notifications about incidents, accidents and safeguarding information. A notification is information about important events which the service is required to send us by law.

As part of the inspection, we undertook visits to two people who received care in their home and spoke to three members of staff, the manager and the operational support manager.

We reviewed a range of documents and records, including care records for people who used the service, records of staff employed, and medication records. We looked at records of disciplinary meetings and a range of quality audits and management records.

Is the service safe?

Our findings

At the last inspection we found that Westminster Home Care had failed to ensure safe and proper management of people's medicines. This inspection was undertaken to check that improvements had been made within the timescale set for compliance. We reviewed the records and practices relating to medicine administration and found that medicines were being managed in a safer way.

We checked a sample of people's medicines against the records and found that details of people's medicines were being correctly transcribed onto administration records for staff to follow. The instructions regarding administration were also clear, for example where people received their medicines via a Percutaneous Enteral feeding tube (PEG). Advice had been obtained from the pharmacist and guidance was documented for staff to follow. We looked at the arrangements for individuals who had variable doses of medication such as Warfarin which is a medicine given to prevent harmful blood clots and is adjusted following blood tests. We saw that there was a process in place to advise care staff promptly of changes to the amount of medicine to be administered.

Where individuals were in receipt of PRN, or as and when medicines we found that they were in the process of introducing brightly coloured documentation to highlight this to staff. The manager showed us an example and we saw that it included guidance for staff to follow and the circumstances in which they should administer. Individuals prescribed creams and lotions had body charts in place to show staff where on the body they should be administered and how much to apply

Care plans set out any specific requirements which staff need to be aware of when administering people's medicines such as administering medicines before eating or the need to sit upright following receipt. The responsibilities for delivery and collection were also outlined. Risks such as those surrounding people's capacity and safe storage were identified and guidance given to minimise the risks to individuals.

We checked a sample of medicines against the administration records and found that they tallied. However, where staff took responsibility for collection of medicines they were not consistently documenting the amounts received which made it difficult to audit and check that people were receiving their medicines as prescribed. The manager agreed to follow this up.

Audits were undertaken on a monthly basis and we looked at a sample of these as part of our inspection. These audits were primarily on record keeping rather than on checks on the quantity of medicines and cross referencing them with the records. We discussed this at the inspection and the manager told us that medicines were checked on site as part of spot checks and we saw some records of home visits where staff had recorded "medication checked", although it was not clear from the records exactly what they had undertaken and it was agreed that this could be strengthened.

Where shortfalls were identified in the documentation as part of the auditing process we found that these were followed up with the individual staff and clarification sought. Where there were examples of repeat errors retraining was provided to ensure that staff understood their responsibilities.

Staff received training on the administration of medication. We looked at the training undertaken by a newly appointed member of staff and saw that they had undertaken training and their understanding of what they had taught had been checked. Staff spoken with confirmed that they received regular updates and that their practice was observed to check that they were doing so safely.

The provider's policy on the administration of medication had been identified at the previous inspection as unclear, specifically in relation to prompting and administering. We found that this had not been addressed but following the inspection, we received an amended policy from the providers operational manager