Westminster Homecare Limited

Westminster Homecare Limited (Milton Keynes)

Inspection report

Thomas Grant House
20 Watling Street, Bletchley
Milton Keynes
Buckinghamshire
MK2 2BL

Tel: 01908373734
Website: www.whc.uk.com

Date of inspection visit:
23 September 2016
26 September 2016
30 September 2016

Date of publication:
17 November 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

This responsive inspection was unannounced and took place on 23, 26 and 30 September 2016.

Westminster Homecare Limited (Milton Keynes) is registered to provide 'Personal Care' for people who live at home and in extra care sheltered housing accommodation in and around Milton Keynes and Buckinghamshire. The service provides care for approximately 220 people.

A registered manager was 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.

We were told by the provider that the registered manager's responsibility was to manage the regulated activity 'Personal Care' for people using the service that lived in extra care sheltered living accommodation. The provider told us that interviews were taking place to recruit another registered manager to manage the regulated activity 'Personal Care' for people living in the community. In the interim an acting manager was overseeing this activity.

At the last inspection on the 18 and 21 April, 10 and 12 May and the 1 June 2016 we asked the provider to take action to make improvements. This was with regards to working with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards legislation and the handling of complaints.

This was a breach of Regulation 11(3) (4) (5) and Regulation 13 (7) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We received an action plan from the provider on how the relevant legal requirements would be met.

We had also identified at the last inspection that the systems to oversee and manage people's medicines, for which the provider had taken on the responsibility, was not always effectively managed.

After the last inspection we received information of concern that the service may not have consistently managed people's medicines safely. We therefore inspected the service against one of the five questions we ask about services: is the service safe?

At this inspection we found the audit systems for monitoring medicines administration was not sufficiently robust to drive continuous improvement. This placed people at risk of not always having their medicines consistently safely managed.

You can see what action we 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 monitoring of the medicines administration was not sufficiently robust to drive continuous improvement. This placed people at risk of not always having their medicines consistently safely managed.

Westminster Homecare Limited (Milton Keynes)

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 responsive inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.'

This inspection was unannounced and took place on 23, 26 and 30 September 2016. It was carried out by one inspector and an inspection manager.

We had received information of concern regarding the management of medicines for which the provider had taken on the responsibility. We inspected the service against one of the five questions we ask about services: is the service safe?

Before the inspection we reviewed information we held from notifications the provider had sent to us and other information we had received from safeguarding and local authority commissioners.

During the inspection we reviewed the care records for seven people, for which the provider had taken on the responsibility of administering their medicines. We also reviewed the providers' medicines policy and records of the medicines and daily care audits.

We spoke with the acting manager, the quality manager and the director of operations. We carried out telephone interviews with three people that had their medicines administered to them by staff and five staff that administered medicines to people using the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 18 and 21 April, 10 and 12 May and 1 June 2016. We found the providers' medicines management systems required improvement. This was because the systems to oversee and manage people's medicines were not always effectively managed and the service had not always identified areas requiring urgent action to be taken timely.

After the inspection the Care Quality Commission (CQC) were alerted of concerns from a relative of a person using the service and also the local authority safeguarding team of medicines incidents. The provider had also notified CQC of the medicines incidents as required by law.

Under Section 64 of the Health and Social Care Act 2008 we asked the provider to supply CQC with documentation relating to their investigation into the incidents and we received the information as requested.

The provider told us arrangements had been put in place to update staff with medicines administration and safeguarding training. They also said they had taken action to ensure that 'time critical' calls had at least four hour gaps between the visits, and carers had been scheduled on a permanent basis to provide continuity of staff. During the inspection we saw the care records for the person involved in the medicines incidents had been fully reviewed and updated appropriately.

During the inspection the provider informed us that another person using the service had raised concerns of not always receiving their medicines appropriately. We looked at records of the provider investigation into the concerns. We saw the person's medicines administration record (MAR) and daily logs had been audited by the service. We found the audit of the MAR had identified numerous gaps in staff signatures, but there was insufficient evidence to demonstrate what action the provider had taken in response to their findings.

We saw that audits had taken place on the daily logs the staff wrote at the end of each visit. The audit process was intended to check that the logs gave sufficient detail. However some entries were very brief and required closer scrutiny. For example, one entry simply said, 'Phoning the office about the antibiotics'. There was no reference in the audit of the entry being identified as requiring any further explanation or closer investigation.

Within the MAR charts we looked at during the inspection, we found errors such as, gaps in dates, gaps in staff signatures and the reasons for people's medicines not being given was not always recorded. The provider told us they were unable to archive completed MAR charts at the office, as they were considered to be the property of the district nursing services. They told us they had recently purchased a scanner so that a digital copy of the MAR charts could be taken and stored at the agency office. It was anticipated that having copies of the MAR charts available alongside the records of the MAR audits would improve the systems of the MAR review process.

Some people using the service had their medicines held within a 'dosett box', monitored dosage system that

contained one month's supply of their prescribed medicines. They explained the medicines were put in the dosett box by the pharmacist and a list of the medicines contained within the box was written by the pharmacist on the reverse, along with a description of each tablet, for example, the colour and shape.

Staff confirmed that some people also had their prescribed medicines listed in their support plans, but this was not always consistent for everybody they provided care for. The records we viewed at the time of the inspection also confirmed that some care files contained a list of medicines the person was prescribed whilst some did not list the medicines people were prescribed.

We looked at the provider's medicines policy that informed the frequency of medicines audits was to take place every six months, but we found in practice it was happening around every 12 months. One member of staff said, "[Name of field supervisor] came out today to check the MAR chart, for [name of person], but this is the first time to my knowledge this has been done." One member of staff said, "I think they have now started to check the MAR's more often." Another member of staff said, "I think the MAR charts are looked at during the spot checks. I had one done around June time this year and then another soon after."

We found the audit systems for monitoring medicines administration was not sufficiently robust to drive continuous improvement. This placed people at risk of not always having their medicines consistently safely managed.

This was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The comments we received from people using the service confirmed they were satisfied with how their medicines were managed by the service. For example people said, "I get my medicines on time." "The staff give me my pills, they know what they are doing, I have not had any problems." "The staff get my tablets for me and a drink; they put them in my hand, so that I can take them myself." "I know the carers record down when I have taken my tablets, I have seen them do it."

The staff confirmed the medicines' training was thorough. They confirmed that observations took place to assess their competency to administer medicines. They understood the importance of administering people's medicines safely and were aware of how people preferred to take their medicines. One member of staff said, "The medicine training is really good, I don't think you can fault it." Another member of staff said, "[Name of the trainer] is very thorough; he goes through the difficulties we can come across, when giving people their medicines." Another member of staff said, "I always follow the five R's when administering medicines; the Right medicine, the Right person, the Right dose, the Right time and the Right route. I take giving people their medicines very seriously."

The staff told us they were aware of the importance of keeping accurate medicines records and what to do in response to any medicines concerns. One member of staff said, "If I made any mistakes, I would call the person's GP and the office immediately." Another said, "I informed the staff in the office, when I found the MAR charts had not been signed properly. I also made a note in the daily notes. It is very important that recording errors are picked up sooner rather than later." Another said, "It frustrates me when the dates on the MAR charts get mixed up, I think it is because they are handwritten, staff forget what date it is and it creates confusion, that's when mistakes happen."

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 monitoring of medicines administration was not sufficiently robust to drive continuous improvement. This placed people at risk of not always having their medicines consistently safely managed.