Westminster Homecare Limited

Westminster Homecare Limited (Milton Keynes)

Inspection report

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Date of inspection visit:
23 January 2017

Date of publication:
10 March 2017

Ratings

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

Summary of findings

Overall summary

This focused follow up inspection was announced and took place on 23 January 2017.

Westminster Homecare Limited (Milton Keynes) is registered to provide 'Personal Care' for people living at home and within independent living accommodation in the Milton Keynes, Buckinghamshire and Central Bedfordshire area. At the time of the inspection the service was providing care for approximately 180 people.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 of the service that was carried out on the 23, 26 and 30 September 2016, requirements were made in relation to Regulation 12 of the Health and Social Care Act Regulations 2014. This was because monitoring records on the medicine administration systems were not sufficiently robust to drive continuous improvement. This placed people at risk of not always having their medicines consistently managed safely. We asked the provider to take action to make improvements and we received an action plan from the provider telling us how the legal requirement would be met.

We undertook this inspection to check that they had followed their action plan to meet the legal requirement. This report only covers our findings in relation to the requirement that had been made. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Westminster Homecare Limited – Milton Keynes on our website at www.cqc.org.uk

Where the provider had taken on the responsibility to administer people's medicines, suitable systems had been put in place to ensure medicines were managed safely.

All care staff and field support workers had been provided with updated medicine administration training. The medication policy and procedure had been reiterated to all staff that administered medicines to people using the service. The importance of completing the medicines administration records (MAR) charts correctly had been stressed to all staff. This had also been included as a set agenda for discussion during staff one to one supervision meetings and general team meetings.

Field care supervisors had received re-fresher training on the safe handling of medicines, care planning and on completing medicines risk assessments.

The medicine administration support plans had been reviewed and updated as required, to make sure the information was current and reflected how people wished to take their medicines.

The medicine audit process had been reviewed and strengthened and MAR charts were being reviewed on a

regular basis.

The call times for all people that required staff to administer their medicines had been reviewed to .ensure 'time critical' medicines were administered to people at the specified time.

Medicine audit systems had been strengthened to ensure they took place as scheduled and areas identified for improvement were addressed and relevant action taken to continually improve the service.

While improvements had been made, we have not revised the ratings for the key questions; to improve the ratings to 'Good' would require a longer term track record of consistent good practice. We will review our ratings for safe' at the next comprehensive inspection.

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 safe.

Where the provider had taken on the responsibility to administer, people's medicines; robust auditing and monitoring systems had been put in place to drive continuous improvement.

While improvements had been made, we could not change the rating for 'safe', because to do so requires good practice over time. We will check this during our next planned comprehensive inspection.

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 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 was done to check the improvements planned by the provider to meet the legal requirements, after our inspection on 23, 26 and 30 September 2016 had been achieved. 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.

The inspection took place on the 23 January 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the office. The inspection was carried out by two inspectors.

Before the inspection we reviewed the providers' action plan from the last inspection. We also reviewed information we held about the service including statutory notifications. A notification is information about important events which the provider is required to tell us about by law. We also contacted commissioners and the local authority safeguarding teams involved in monitoring the care of people receiving care from the service.

During the inspection we spoke with the registered manager and the area manager. We looked at the medicine risk assessments and support plans for 10 people using the service and the medicine audit records. This was to establish what steps had been taken place to improve the medicine management systems.

Requires Improvement

Is the service safe?

Our findings

During our inspection carried out on 23, 26 and 30 September 2016 we found records on the monitoring of the medicine administration systems were not sufficiently robust to drive continuous improvement. This placed people at risk of not consistently having their medicines managed safely. .
The service was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that the provider had made significant improvements to the medicines administration monitoring systems.

The registered manager said, "I am confident that the requirement has been met. We have really worked hard to improve on the medication systems." She told us about the changes that had been introduced to ensure compliance with the regulation. We saw several areas of the service had been improved as a result of the work that had taken place.

Where the provider took on the responsibility of administering people's medicines we found the support plans had been reviewed and updated and included information on the medicines that people had been prescribed. Each person had a risk assessment in place in relation to their medicines administration requirements. This ensured that staff had clear guidelines in place to enable them to support people appropriately with the administration of their medicines.

The assessments contained the current list of people's prescribed medicines and included information to address any potential hazards or risks to the person in relation to their prescribed medicines.

All staff involved in administering and overseeing medicines administration had received re-fresher medicine training. The training had stressed the importance for changes in people's prescribed medicines to be fully updated in the care and support plans without any delay. The support plans we viewed at the time of the inspection all contained sufficient information on the current medicines people were prescribed.

The systems to check that people received their medicines as prescribed had been fully reviewed. We saw that timescales had been set up to ensure that medicines were reviewed at the beginning of a care package and then again every six months or sooner should any changes take place to the medicines people were prescribed. The MAR charts had been routinely audited and where any irregularities found, they had been addressed with the individual staff member that had administered the medicines. This ensured that staff were consistently reminded of the importance of keeping robust MAR documentation in line with best practice guidelines.

The provider ensured that people were receiving their medicines at the prescribed times. The registered manager told us that staff were made aware that the medicine administration times could not be changed. If they are running late for any reason they had to contact the office. This was to ensure that alternative arrangements were made for the person to receive their medicines at the prescribed time.

The medicine administration record (MAR) clearly specified the medicines people were prescribed to be taken regularly and those to be taken as required. In addition 'time critical' medicines were also clearly specified on the MAR charts so they were administered to people at the right time.

Portable scanners had been purchased to enable the care supervisors to scan the MAR charts so they could be transferred to the agency office for full review as part of the medicine auditing process.

The importance of staff completing MAR charts correctly, along with keeping detailed records in people's daily notes was a set agenda item at staff one to one supervision and staff team meetings. In addition information on any changes to people's medicines was communicated to staff by text and e-mail messages.