Bexley Homecare Services Ltd

Carewatch (Bexley)

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 carried out an announced comprehensive inspection of this service on 02 and 03 August 2016 and took enforcement action. We served warning notices on the provider and registered manager in respect of a breach found of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This breach related to concerns regarding the safe management of people's medicines. There was not always sufficient guidance in place for staff to ensure people's medicines were administered safely, and records relating to people's medicines were not always accurate or had not always been completed correctly.

We carried out this announced focused inspection on 03 November 2016 to check that the provider had met the requirements of the warning notice. We gave the service two working days' notice of the inspection because the service provides a domiciliary care service and we wanted to be sure the registered manager would be available.

At this inspection we looked at aspects of the key question 'Is the service safe?' This report only covers our findings in relation to the focused inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Carewatch (Bexley)' on our website at www.cqc.org.uk. The provider was still in the process of addressing other breaches of legal requirements at the time of this inspection, in line with their action plan. We will follow up on these at a later date.

Carewatch (Bexley) provides personal care and support to approximately 100 people in their own homes in the London Borough of Bexley. The service had 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 this inspection we found a breach of regulations because whilst the provider had taken action to address the issues identified at the last inspection, we also found some residual concerns in the recording of people's medicines support, and medicines audits were not always effective in identifying issues or driving improvements. Following our inspection we wrote to the registered manager regarding these concerns and they submitted further evidence to demonstrate that people's medicines had been administered safely.

We also identified a further breach of regulations because staff had not identified or acted on a safeguarding concern identified during the inspection process. This related to the support one person required with their medicines whilst not receiving services. 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

Further action was required to improve safety.

Whilst the provider had acted to improve the safety of the management of people's medicines, further improvement was required to the recording of people's medicines support. Medicines audits were not always effective in identifying issues and did not always drive improvements.

The provider's systems were not always effective in identifying and acting on the risk of abuse.

Carewatch (Bexley)

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. We undertook an announced focused inspection of Carewatch (Bexley) on 03 November 2016. This inspection was done to check that improvements had been made to meet required legal requirements in response to the enforcement action we took following our 02 and 03 August 2016 inspection. The inspector inspected the service against aspects of one the five questions we ask about services: 'Is the service safe?' This is because the service was not meeting legal requirements in response to part of that key question at the last inspection.

The inspection was undertaken by one inspector, and was announced. We gave the service two working days' notice of the inspection because the service provides a domiciliary care service and we wanted to be sure the registered manager would be available. Before the inspection we reviewed the information we held about the home. This included notifications submitted by the provider. A notification is information about important events that the provider is required to send us by law. We used this information to inform our inspection planning.

During our inspection we spoke with the registered manager, three staff and one relative. We looked at records, including nine people's medicines records and other records relating to the management of medicines within the service.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection on 02 and 03 August 2016 we found a breach of regulations because there was not always sufficient guidance in place for staff on how to safely support people with their medicines. We also found inconsistent information about the medicines people had been prescribed and that people's Medicines Administration Records (MARs) had not always been signed by staff to confirm people had received their medicines as prescribed.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). We took enforcement action and served a warning notice on the provider and registered manager, requiring them to meet this regulation.

At this inspection on 03 November 2016 we found that the provider had made improvements to the management of people's medicines in response to the issues identified in the warning notices. However, we also identified some residual concerns regarding the recording of the support people had received with their medicines. For example, one person's care plan made reference to the need for staff to support them with medicines at two visits each day, whilst their medicines administration record (MAR) indicated that support was required at three visits. This meant there was a risk that staff unfamiliar with the person's needs would not be aware to support the person with their medicines during one visit, when following their care plan.

In another example, we were unable to confirm whether staff had supported a person correctly with their medicines during the month of September 2016 because the MAR provided by staff only covered the final week of the month. Staff we spoke with explained that the person had been in hospital during the month and that the record related to the time following their discharge. However, they were unable to find a MAR relating to the time prior to the person's hospital admission at the time of our inspection. This meant we were unable to confirm whether they had received their medicines as prescribed during this time.

Medicines audits conducted by the service did not always identify issues, and where issues had been identified, action had not always been taken to drive improvements. For example, an audit of one person's MAR had not identified that staff had recorded the administration of an additional dose of a medicine that had been prescribed to be taken weekly. Following our inspection senior staff confirmed that they had investigated this issue and identified that this was a recording error and that the person had received the medicine correctly, as prescribed.

Another audit of one person's MAR from August 2016 identified that staff had not always correctly signed to confirm the person had received their medicines as prescribed. However, there was no record of any action taken to address the issue, and we found that an audit of the same person's MAR from September 2016 identified the same issue. This meant we could not be assured that the person had received their medicines as prescribed consistently during the two months when the concern should have been addressed after the first audit.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities

Regulations 2014). Following the inspection we wrote to the registered manager about the issues we had identified. They submitted further evidence to demonstrate that the people in question were currently receiving appropriate support to take their medicines as prescribed.

Where people were prescribed 'as required' medicines we saw there was guidance in place for staff on how to support people safely. For example where one person had been prescribed a medicine for pain relief we saw guidance in place for staff to ensure they maintained a minimum time gap between each dose, in line with the medicine's instructions. Staff we spoke with were aware of this guidance and records confirmed that the medicine had been managed safely by staff.

The provider's systems were not always effective in identifying and acting on the risk of abuse. One person's MAR had been completed by staff to indicate that they had not taken their prescribed medicines on six days during September 2016. We spoke to senior staff about this and they explained that the medicines had been missed on days when they didn't provide the person with support; therefore the service was not responsible for the management of the person's medicines on those occasions. However, the provider had not identified that this meant the person's medicines were not being given as prescribed consistently, and had not taken any action to inform the local safeguarding team or prevent the risk of the person missing further doses of their medicines.

These issues were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). Following the inspection senior staff confirmed that the local authority safeguarding team had made arrangements to ensure the person received daily support to take their medicines as prescribed.

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 Medicines were not always managed safely.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from abuse.