Nestor Primecare Services Limited

Allied Healthcare Lechlade

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Requires improvement

Overall summary

We inspected Allied Healthcare Lechlade on 6 July 2015. Allied Healthcare Lechlade support people living in their own homes.

We carried out an unannounced comprehensive inspection of this service on 13 April 2015. Following the comprehensive inspection this provider was placed into special measures by CQC. We found the provider was not meeting the legal requirements of four of the fundamental standards. After the comprehensive inspection, we took enforcement action and issued two warning notices to require the provider to meet the legal requirements of two of the fundamental standards (Regulation 12 and Regulation 17). This inspection in July 2015 was to check they had met the legal requirements of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which relates to people's safe care and treatment. This report covers our findings in relation to this requirement. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Allied Healthcare Lechlade on our website at www.cqc.org.uk

There was no registered manager at the service. 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. The provider was trying to recruit a registered manager.

Since April 2015 the provider had improved the system for the management of medicines and staff always had medicines records to complete in people's homes. However there were still improvements needed as medicines records were not always completed and did not always contain detailed information to support staff with giving medicines safely.

Summary of findings

There was guidance in place to support staff to deliver care in a safe way that minimised risks for people. The provider had reviewed and updated people's care plans. People's care plans contained detailed risk assessments and where people's needs had changed risk assessments had been updated.

The provider had improved the system for monitoring visits to reduce the risk of missed and late visits. Where people required two staff members to meet their care needs these were being provided. People told us they had not experienced missed visits since April 2015 and the system indicated there had been no missed visits. However, people were still experiencing late visits.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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 always safe. We found that action had been taken to improve safety of medicines, however medicines records were not always completed and we could not be sure people received their medicines as prescribed.

People's care files contained detailed up to date risk assessments.

People were supported by sufficient staff to meet their needs. There was a system in place to monitor visits and minimise the risk of missed visits.

We have improved the rating for safe from inadequate to requires improvement as a result of the improvements made.

Requires improvement

Allied Healthcare Lechlade

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 unannounced focused inspection of on 6 July 2015. The inspection team consisted of one adult social care inspector and one pharmacy inspector. This inspection was done to check that improvements to meet legal requirements planned by the provider after our inspection in April 2015 had been made. The team 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 and regulations associated with the Health and Social Care Act 2008.

During our inspection we looked at eight people's care records, which included records relating to medicines. We looked at systems for monitoring visits. We spoke with a registered manager from another Allied Healthcare location, who was managing the service while the operations manager was on leave, two office staff, a field care supervisor and four care workers.

Following our inspection we spoke with one person who used the service, and four relatives.

Requires improvement

Is the service safe?

Our findings

During our last inspection in April 2015 we found that the provider did not have a proper and safe system in place in relation to medicines. Medication administration records (MAR) were not always available in people's homes so staff were not able to record the medicines they gave people. It was not possible to check whether people had been given their medicines as prescribed. These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took enforcement action advising the provider they must make improvements to meet the legal requirements by 22 May 2015.

At the July inspection we found that some improvements had been made. However, there were still some improvements needed. We looked at the MAR and care records for eight people using the service, who received support with their medicines from care staff. We saw gaps in seven of the records we looked at. Staff had not always recorded the person had taken their medicine or recorded the reason, if they were not taken. Records did not always show whether people had taken their medicines as prescribed. One person had been prescribed a medicine to be taken on alternate days but staff had recorded they had given this every day. It was not clear whether this medicine had been administered incorrectly or the record was incorrect.

Clear instructions were not always available to help staff give people their medicines safely. For example we saw one person had been prescribed a medicine to be given once a week. This medicine has some specific instructions about how to take it safely and effectively. These instructions were not included on the MAR sheet or in the care plans we saw. It was not clear whether the person would be given this medicine in a safe way. One person was prescribed Paracetamol to be given 'when required'. There were no dose instructions on the MAR sheet indicating how often this could be given or the reason for administering it. Two people were prescribed a medicine that needed careful monitoring to make sure the right dose was given. It was not clear from these people's care records how staff would assure themselves they were giving the correct dose. This increased the risk that people's medicines may not be given safely.

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

Staff we spoke with confirmed that since April 2015 systems had been put in place to ensure that MAR were available in people's homes for them to complete. Comments included: "MAR have absolutely improved"; "MAR charts are all in place" and "MAR charts are more reliable". One member of staff told us that if there were any changes they could contact the office; they would make the necessary checks and amendments to the record sheets. Another staff member told us office staff could check when new MAR sheets were needed in a person's home and make sure they were in place at the right time.

At the inspection in April 2015 we found risks to people were not always assessed. Where risk assessments were in place they were not always fully completed or accurate. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took enforcement action advising the provider they must make improvements to meet the legal requirements by 22 May 2015.

At our inspection in July, we found that improvements had been made. People's care plans contained detailed risk assessments. Where risks were identified care plans contained details of how the risk would be managed. For example, one person was at risk of falls when transferring. The care plan identified the person's support needs and that a riser chair was in place to assist the person. We spoke to staff who were aware of the person's support needs.

The April 2015 inspection identified the provider did not have appropriate systems in place to mitigate the risk of missed visits. People did not always receive support from sufficient staff to meet their needs. These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took enforcement action advising the provider they must make improvements to meet the legal requirements by 22 May 2015.

At the inspection in July we found improvements had been made. The provider was using an electronic timed monitoring system to enable visits to be closely monitored. The system alerted the senior member of staff on duty if a call had not been made within 15 minutes of the due time.

Requires improvement

Is the service safe?

The senior member of staff on duty told us they would then contact staff to find out where they were. People told us visits had improved and no-one we spoke with had experienced a missed visit. However, people told us visits were sometimes late and they were not always told.

People we spoke with, who required two staff to meet their needs, told us two members of staff always came. Records confirmed where people needed two staff to support them they were consistently deployed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 provider was not doing all that is practicably reasonable to mitigate the risks associated with the administration of medicines. Regulation 12 (1) and (2) (g)