Kumari Care Limited

Kumari Care

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out a comprehensive inspection of Kumari Care on 11 and 12 December 2017. At this inspection the service had not met the regulation relating to Safe Care and Treatment in regards to medicine administration. Following this inspection the provider submitted an action plan detailing the steps that would be taken to meet this regulation. The provider had been submitting fortnightly reports to inform the Care Quality Commission of the progress made to address the areas identified in medicines administration.

We undertook a focused inspection on 9 April 2018 to check the provider had completed the areas set out in their action plan. You can read the report from our last comprehensive by selecting the, 'All reports' link for 'Kumari Care' on our website at www.cqc.org.uk

Kumari Care provides domiciliary care to people in their own homes in the Bath, Bristol and South Gloucestershire areas. Kumari Care provides a service to approximately 200 people.

There was 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 the provider had taken action to progress towards meeting the warning notice. However, further elements of the regulation needed to be met.

We found two breaches 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 this 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

Improvements were not sufficient in medicine administration.

Is the service well-led?

Requires Improvement

The provider had not fully implemented their action plan. Audits were not yet effective in instigating changes.

Kumari Care

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. The inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook a focused inspection of Kumari Care on 9 April 2018. During this inspection we looked at the progress the service had made implementing their action plan to improve medicines administration.

The inspection was unannounced and undertaken by two inspectors. One an adult social care inspector and one a pharmacist specialist inspector.

We inspected the service against two of the five questions we ask about services: is the service safe and well-led. This is because the breach in safe care and treatment identified at the last comprehensive inspection and focused on at this inspection was in relation to these questions.

During our focused inspection we spoke with the registered manager, nominated individual and one staff member. We reviewed 13 medicine administration records and 10 care plans. We reviewed the quality audit system in regards to the safe administration of medicines and action plan produced by the provider.

Requires Improvement

Is the service safe?

Our findings

The service did not have suitable systems in place to ensure that medicines were consistently managed safely. At our last inspection of Kumari Care in December 2017 we found improvements were required in the safe administration of medicines. Care plans did not give enough information and guidance on how to support people with their medicines and Medicine Administration Records (MAR) were not being completed fully or accurately

At our last inspection of Kumari Care we found that MARs were not being collected from people's homes regularly to enable thorough checks to be completed. The service's action plan had detailed that all MARs would be collected from people's homes between the first and fourth of the month. At our inspection on the ninth of the month only 13 MARs were available to view from 31 identified as in use in March 2018.

MARs were not always fully completed. The front sheets of the MARs had space for information about the person, their name, address, known allergies, telephone number of the doctor and supplying pharmacist. However we found that these were not completed in full. On some MARs, there was no information to say who it related to, the dose of medicine to be administered or the time to be taken. For example, on one it said, "Take one a day" but did not refer to what time of the day the medicine should be taken. For some medicines the time of day they are taken is important in ensuring they are administered as prescribed. The month and start date were not recorded on some MARs, so it was unclear what dates they referred to.

Staff did not always record medicines administration accurately. Gaps on the MARs meant the provider and health professionals could not be sure the person received their medicines as prescribed. At our last inspection, staff ticked the MAR to indicate medicines had been given. This had improved and staff were using their initials. However, on some occasions it appeared that the person had not received the medicine as the MAR was coded as asleep, but the provider told us that this was the care workers first initial. There was a space at the bottom of the MAR for staff to put a sample initial to identify whose initial was whose. This had not always been completed by all staff administering medicines.

Where people were receiving topical medicines, MARs did always not indicate the frequency of application or detail where on the body these should be applied. For example, for one person their MAR stated the cream and "External use only." The MAR had been signed twice, three times or four times a day. It was unclear how often the cream should be applied. Neither the MAR or care plan indicated where on the body the cream should be applied.

We reviewed training records. All staff administering medicines had completed training in the safe administration of medicines. As part of this training, scenarios had been presented to care staff to assess their understanding and competency. However, not all staff had a competency assessment. This meant for some staff members the training had not yet been embedded into practice.

Within the care plans, we found that the medication support plans were either not present, partially completed or contained conflicting information. Care plans did not provide full information for staff about

how to support the person with their medicines. Care plans that had recently been reviewed and changed in line with the provider's action plan did not contain sufficient information to support staff. For example, a current list of medicines or how the person preferred to take their medicines.

This means that people could not be assured that they would receive their medicines safely and in a way they would wish to.

This is a continued Breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

The service continues to have shortfalls in the monitoring arrangements to ensure people receive safe, good quality care. After our last comprehensive inspection in December 2017 the provider had submitted fortnightly reports. This was to monitor and review the progress of their action plan in regards to the safe administration of medicines.

We found that the quality tracker used by the service was not always fully accurate. Four people had MARs returned having been completed in March 2018. However, these people were not identified on the tracker as being in receipt of medicines support from the service. For example, one person was supported by a relative not the service. From people's care plans it was not always clear how the service supported people with their medicines or if at all.

The provider had audited the MARs received in February 2018. However, the quality tracker indicated that not all MARs had been collected. Only 33% had been collected and audited. Each MAR collected had been audited and comments made. These included identifying gaps in recording and lack of completed details. No overall summary had been collated of the findings. Some actions had been noted. For example, speaking to staff and ensuring correct MARs were in place. However, these did not note which staff, how these actions would be done or if this had been completed.

The provider's action plan identified that all care plans would include a medication support plan by 2 April 2018. This had not been completed. This meant care records lacked current and correct information in supporting people with their medicines

The provider's medicine policy had been reviewed and updated and was introduced for use on the day of our inspection as detailed in the provider's action plan. The provider's process did not yet follow the medicine policy. As the information to be contained in people's care plans for example, how people's medicine were to be administered and stored was not always evident in care plans that had been recently reviewed by the service.

This is a continued Breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meetings had been held with staff members to highlight the improvements required in medicine administration in March 2018. Examples had been discussed of errors identified and the correct completion of MARs. Further support was required for staff in the safe administration of medicines.

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 provider had not ensured that guidance in care plans and practice in relation to medicines was sufficient to ensure people's safety.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured their quality monitoring systems had effective processes for minimising risks identified to people.