James Sanderson Limited

Caremark (Bromley)

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 11 and 12 May 2016 during which we found breaches of regulations. Medicines were not safely managed in that anti-coagulant medicines were not administered in line with the provider's policy and medicine administration records (MAR) did not always accurately reflect the medicines people were prescribed. These issues placed people at risk of unsafe care. Following the inspection we served a warning notice on the provider and registered manager requiring them to comply with the requirements of the regulation.

We also found that risks to people had not always been adequately assessed. The provider did not have appropriate systems in place to ensure people were appropriately assessed in line with the requirements of the Mental Capacity Act 2005. Appropriate recruitment checks for staff were not always in place and the provider had failed to submit notifications to CQC as required by the regulations. There were no effective systems in place to receive and respond to complaints, or to monitor and improve the quality of the service.

These issues were breaches of the regulations of the Health and Social Care Act (Regulated Activities Regulations 2014). We asked the provider for an action plan to make improvements to the issues identified above. We will check on the action the provider has taken in relation to the requirement notices at our next comprehensive inspection.

We undertook this announced focused inspection on 28 September 2016 to check that the provider had met the requirements of the warning notice. At this inspection we looked at aspects of the key question 'Is the service safe?' We also looked at the provider's management of incidents following information received from notifications the provider submitted to us. 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 'Caremark (Bromley) on our website at www.cqc.org.uk.

Caremark (Bromley) is a domiciliary care provider located in the London Borough of Bromley, providing care and support to people across the borough and surrounding areas. There was a registered manager in post at the time of our inspection. 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 that the provider had made improvements to the areas we had identified at our previous inspection in relation to anti-coagulant medicines and the recording of people's medicines on MARs.

However, we also found that medicines prescribed 'as required' were not always administered at the recommended dose intervals in line with the prescriber's instructions, and the provider did not always record 'as required' medicines in line with their policy.

This was a continued breach of Regulation 12 of the Health and Social Care Act (Regulated Activities Regulations 2014). However, following our inspection we wrote formally to the provider requiring them to confirm the action they had taken to ensure compliance with the regulation. We were assured the provider had taken appropriate actions in response to our inspection, and therefore we will continue to monitor the service and check on the provider's progress with this at our next comprehensive inspection.

We also found that the provider had appropriate systems in place to investigate, monitor and respond to incidents.

As a result of the findings of this inspection, we have reviewed the rating for the key question 'Is the service safe?' which remains rated as 'Requires Improvement' because of the further issues we identified regarding the unsafe management of medicines. Therefore there is also no change to the overall rating for the service which remains 'Requires Improvement'.

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

We found that action had been taken to improve the issues we found at our last inspection, however medicines were not always managed safely.

People were not always administered their medicines in line with clinical guidelines, and PRN (as required) medicines were not always accurately recorded.
The provider had effective systems in place to monitor and manage any incidents, including any safeguarding allegations.

The rating for this key question remains as 'Requires Improvement' because although the provider had made improvement to address the concerns found at our last inspection, some medicines issues still required improvement.

Caremark (Bromley)

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 Caremark (Bromley) on 28 September 2016. This inspection was done to check that improvements to meet required legal requirements after our 11 and 12 May 2016 inspection had been made. The service was inspected against aspects of 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 was carried out by one inspector, a pharmacist and an Expert by Experience (ExE). An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The provider was given 48 hours' notice because the location provides a domiciliary care service and we wanted to make sure the registered manager was available.

Before the inspection we reviewed the information we held about the service. 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 also contacted a local authority who commissioned services from the provider to get their feedback on the quality of the service. We used this information to inform our inspection planning.

During our inspection we spoke with the registered manager, the director, four members of staff, seven people using the service and six relatives. We looked at records, including eleven people's medicines records and other records relating to the management of the service including audits and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 11 and 12 May 2016 we found a breach of regulations because medicines were not managed safely. The provider was not managing anti-coagulant medicines in line with the provider's policy. Medicines risk assessments did not always reflect the medicines that people were prescribed and the provider had not always sought appropriate guidance from the prescriber.

These issues were in 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 the regulation.

At this inspection we found that improvements had been made to the management of medicines in respect of the issues we had previously identified.

However, we also found some new concerns in relation to the management of people's 'as required' medicines, and because the provider was not following their own policy in relation to 'as required' medicines

For example, one person had been prescribed paracetamol but the times of administration had been set to match the provider's visit times. This meant that there was only two and a half hours between two of the doses. Therefore staff had not ensured the minimum safe time gap of between four and six hours had elapsed between doses when supporting the person to take their paracetamol, placing them at risk of harm. We also found that one person's 'as required' medicines had been recorded on their medication administration record (MAR), rather than on a separate 'as required' medicines sheet, in line with the provider's medicines policy.

These issues were a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). We raised the issue regarding unsafe paracetamol administration with the provider at the time of inspection and they contacted the person's GP to ensure the person was safe. The GP provided new instructions for the administration of paracetamol which the provider confirmed they would adhere to. The provider also told us that they would carry out an audit of all people's medication administration records.

Following our inspection we formally wrote to the provider for confirmation that people's files had been audited and control measures put in place to mitigate future risk. The provider confirmed and sent us records to show that people's files had been appropriately audited to ensure that medicines instructions were accurate and reflective of people's needs. Where people were prescribed 'as required' medicines the correct way of recording this had also been implemented. We were assured that the provider had taken some immediate action to address the issues we found at this inspection; therefore we will continue to monitor the service and will check on the provider's improvements in this area at our next inspection.

People that we spoke with told us that they received their medicines when they needed them, and spoke

positively of the support they received in this area. One person said, "I do my own medication but my carer always checks that I have taken the pills."

Staff that we spoke with understood their responsibilities in supporting people with their medicines, including recording on the MAR and reporting any medicines errors. One staff member told us, "I check the medication box and that the name corresponds, and make sure I read the literature to know what to give." Another staff member said, "I check what the medication box says, record on the MAR and check it is the same on the MAR and the packet. I always read the medicine boxes first and then give to the person."

Improvements had been made to the management of anti-coagulant medication. The provider had a designated manager in place to manage anti-coagulant medicine information as well as updating staff training in this area. The provider had special instructions in place to manage the three people on anti-coagulant medicines and had put in place a dosage schedule to support staff understanding. Records showed that the original dose instructions were kept with each person's MAR and that these were reviewed appropriately.

People's medicines records included details of their medicines, what they were taken for, and any side effects people may suffer. Appropriate risk management plans were also in place to ensure that people were supported to take their medicines safely.

The provider undertook regular medicines audits and systems were in place to ensure that any issues identified were highlighted to staff to ensure improvements were made. Records showed that staff were up to date with their medicines competency assessments.

At this inspection we looked at the provider's management of incidents following information received from notifications the provider submitted to us.

The provider had effective systems in place to respond to any allegations of abuse. The registered manager had a manager monitoring action plans in place to review keys areas in relation to any safeguarding issues, including any action taken to mitigate future risk. Records showed that the provider had liaised regularly with other professionals including the local authority and police to ensure that incidents were updated and monitored internally

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 'As required' medicines were not always administered safely. The provider did not always record 'as required' medicines in line with their policy.