London Care Limited

London Care (Raynes Park)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 10 March 2017 and was announced. At our last inspection on 4 and 5 August 2016 we found four breaches of legal requirements in relation to staffing, safe care and treatment, person-centred care and good governance. The provider wrote to us with their action plan on 27 September 2016 and told us they would resolve these issues by 30 November 2016 although some actions would be ongoing.

London Care (Raynes Park) provides personal care and support to people living in their own homes. This includes both younger and older adults and people who may be living with dementia. At the time of our inspection there were approximately 450 people using the service. 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.

The purpose of this inspection was to check the improvements the provider said they would make in meeting legal requirements. At this inspection, we found that although the provider had made some improvements, particularly in regards to staffing, they were still in breach of the regulations in relation to safe care and treatment, person-centred care and good governance.

Medicines were still not managed safely. Medicines records contained unexplained gaps, misspellings and other errors so we could not always be sure people received their medicines as prescribed. Some records showed people did not receive medicines at the correct times and some medicines such as topical ointments were missing from medicines records. There was insufficient information about the medicines people took, what they were prescribed for and the support people needed to manage long-term health conditions safely.

People's risk assessments were not sufficiently personalised and in some cases were completed incorrectly. Some people did not have any assessments of specific risks associated with their care or their health. We did not always find evidence that staff were following risk management plans designed to keep people safe from the risks of skin deterioration.

We also found that care plans still did not contain an appropriate level of detail for staff to provide person-centred care. They did not always take into account the specific support people needed, for example around personal care, continence care or diabetes management. Care plans sometimes contained contradictory information or did not contain any details about people's preferences as to how staff carried out care tasks. However, the care plans did contain information about people's preferences in relation to food, their life history and family relationships and some information about communication needs.

Although the provider carried out a range of audits and checks and had taken some action to address the shortfalls we found, the measures they took to do this were not effective. Despite carrying out extra audits

and checks, additional staff training and supervision and assigning lead roles to senior staff, the provider had not made sufficient improvements to meet the required standards within an appropriate timescale. However, we did note that the quality of some records, particularly daily records staff kept of the care they provided to people, had improved since our last inspection.

We are taking further action against the provider for a repeated failure to meet the regulations in relation to safe care and treatment, person-centred care and good governance. Full information about CQC's regulatory response to any concerns found during inspections is added to the back of reports after any representations and appeals have been concluded.

There were enough staff to keep people safe. The provider monitored staffing levels on an ongoing basis and took steps to recruit new staff when numbers became low. The provider regularly checked to ensure people were receiving all of their planned visits and that staff arrived at their homes punctually. People had also indicated that they were pleased with the quality of service thy received in general.

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 not consistently safe.

Medicines were not managed safely. People did not always receive medicines as prescribed and accurate records of these were not maintained.

Risk assessments were not sufficiently personalised to ensure staff had the information they needed to keep people safe.

There were enough staff to care for people safely.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans did not always contain personalised information about people's preferences, how their care should be delivered or how to support them to stay healthy.

However, staff did have access to some information about people's backgrounds and the support they needed in other areas.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was a range of audits and checks, which the provider used to identify shortfalls in the quality of the service.

However, they did not always take appropriate action to rectify the shortfalls within an appropriate time period.

The provider checked regularly to ensure people were happy with the service they received.

London Care (Raynes Park)

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 took place on 10 March 2017 and was announced. We gave the provider 48 hours' notice because we needed to be sure that the manager or senior staff would be available at the domiciliary care office. The inspection was carried out by one inspector.

Before the inspection we looked at information we held about the service. This included previous inspection reports, feedback from people who used the service and notifications the provider is required by law to send us about significant events that take place within the service.

During the inspection, we looked at six people's care plans and records, including medicines records. We spoke with the registered manager and two senior managers and we also reviewed documents relevant to the management of the service, such as audits and reviews of staffing levels.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 4 and 5 August 2016 we found a breach of the regulation in relation to safe care and treatment. Medicines were not always managed safely, because appropriate information about people's medicines was not included in people's files and in several cases records either showed people were not receiving medicines as prescribed or were not clear enough to show that they did. There were gaps in records and insufficient information about medicines to be taken only when required. Risk assessments were not personalised enough for the provider to be sure they were assessing, managing and mitigating risks arising from individual needs such as people's health conditions and that they were meeting people's individual needs. People's risk of malnutrition was not always appropriately assessed.

At this inspection we found medicines were still not managed safely. Four people's medicines administration records (MARs) contained unexplained gaps where staff had not signed to indicate they had taken their medicines as prescribed. Some medicines, such as topical skin creams and nutritional supplements, were absent from MARs despite the provider having a policy that these must be added to MARs. We also found mistakes on MARs, including misspelled names of medicines, medicines added to the MAR on the wrong month and incorrect dosages written on MARs. This meant there was a risk that any medical professionals providing care and treatment to people might have incorrect information about the medicines people took.

One person was prescribed a medicine to take weekly but records showed staff did not always administer this on time and the gaps between doses were either shorter or longer than prescribed. Another person was prescribed a medicine to take on an empty stomach but records showed staff always gave the person their medicines after meals. This showed people did not always receive support to take their medicines as prescribed, which could be harmful to them or reduce the effect of the medicines.

People's records still did not contain sufficient information about medicines they were prescribed to take only when required. One person had two medicines to be taken when required but there was no information in their MARs or care plan about the circumstances under which they should take them. This meant there was a risk that people would not receive these medicines as prescribed because of the lack of information about them. We also noted there was no information about why people were prescribed some medicines that would usually be used to treat specific physical or mental health conditions. Several of these health conditions were associated with a number of risks to people's health and safety but their risk assessments did not consider the health conditions or any risks arising from them.

Risks were still not assessed and managed appropriately. Four people's risk assessments, including risk assessments for malnutrition, falls and moving and handling, were not completed correctly so it was not clear whether control measures were effective in reducing risks to people because the level of risk indicated did not always correspond with the management plans indicated. For example, for two people's malnutrition risk assessments, an incorrect medium risk score was calculated indicating a pre-set management plan should be followed that included food supplements, where the assessment actually indicated the people were at low risk and did not require these measures. This meant people were at risk of

having their nutrition or other aspects of their care managed inappropriately.

For one person, we did not find evidence that staff were following their risk management plan for skin deterioration. The risk management plan stated staff should support the person to change their position regularly to relieve the pressure on parts of their body. However, the person's repositioning chart for the two months of records we viewed had not been filled in at all and there were no records in the person's care notes of staff supporting them to change position. This meant the provider could not be sure that the person was adequately protected from the risk of skin deterioration.

Risk assessments were still not personalised enough for the provider to be sure that people were adequately protected from risks. The service used a pro forma template that did not allow space to add additional risks that were specific to individuals, such as those arising from health conditions. For example, one person who had epilepsy, two people who had diabetes, one person who had a condition causing breathing difficulties and one person who required staff to use a hoist to support them to move between their bed and wheelchair did not have any assessments of the risks associated with these conditions or activities. Two people with a similar level of risk of developing pressure ulcers had the same pre-printed risk management plan, which did not take into account individual differences such as the fact that one person used a wheelchair during the day while the other remained in bed most of the time. There was no information about people's preferences or views about how the risks were managed. This meant people's risks may not have been managed safely or in ways that respected their preferences.

The provider continued to be in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 4 and 5 August 2016 we found a breach of the regulation in relation to staffing. We found that there were not always enough staff to keep people safe, particularly at weekends and in the evenings.

At this inspection, we saw the provider used a number of systems to ensure there were enough staff to keep people safe. We saw a tracker the provider used to compare the number of staff employed at any one time with the estimated number of staff required to fill the total hours required to carry out care for all people using the service. Managers told us the current staff complement was slightly below the estimated requirement so the service was in the process of recruiting new staff. However, they were able to demonstrate that the shortfall was not problematic because several staff were willing to take on a small number of extra hours per week until recruitment processes were complete.

The registered manager told us they had introduced a new system where supervisors who were usually office based would cover visits in emergencies and this was working well. The manager had also asked staff to feed back about any problems they encountered that may have been barriers to them arriving at each visit on time, for example road works or other problems that might delay them on journeys between people's homes. We checked visit logs for six people and found they received their planned visits, which were usually on time or within half an hour of the expected time. Feedback from surveys and quality checks the provider had carried out since our last inspection indicated that people were happy with the reliability and punctuality of staff in general.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 4 and 5 August 2016 we found a breach of the regulations in relation to person-centred care. Care plans were not always sufficiently personalised to ensure the service was responsive to people's individual needs. They did not always contain enough details about people's health conditions, likes and dislikes about how they wanted their care delivered or specific details about what support they needed, such as whether they preferred baths or showers and how much they could do for themselves.

At this inspection we found care plans were still not sufficiently personalised to ensure that people's care was meeting their individual needs. Care plans still did not cover what care people needed in relation to health conditions such as epilepsy. We looked at care plans for two people with diet-controlled diabetes and saw that for one person there was information about how staff should support them to meet their dietary needs. However, this information was absent for the other person and records showed that on most days staff prepared foods that may have been unsuitable for a person with diet controlled diabetes to eat on such a regular basis, such as cakes and other foods high in fat and sugar. Additionally, care plans lacked information about other care needs such as the support people needed around their continence. One person's care plan stated that they used continence pads, but there was no information about their level of continence, how often the pads should be changed, whether they needed support with this and if so how they preferred staff to support them with this. This meant there was a risk that people's needs would not be met because there was not enough information for staff about how to do this.

Four care plans we looked at contained no information about how service users preferred to be supported with care tasks such as personal care or eating their meals. We did not see information about what people could do for themselves, although one care plan stated that although the person could dress themselves staff should help them to do this anyway. Because there was no explanation as to why this was, there was a risk that staff did not always support people in a way that met their preferences and promoted their independence.

We found contradictory information in some care plans that meant there was a risk staff would not have the correct information about how to support people. For example, one person's care plan stated that they did not communicate verbally but later instructed staff to ask them what they wanted to eat. Because there was no detailed information about how the person communicated, this meant there was a risk that staff supporting the person would not have the information they needed to communicate effectively with them. Another person's care plan stated that they only liked fresh home-cooked meals but later instructed staff to prepare microwave meals for them. This meant there was a risk that people were not always supported in line with their preferences.

The provider continued to be in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Notwithstanding the above, we found some personalised information in care plans around other aspects of people's care. There was some information about people's life history, family relationships, mobility and

details of what support they needed to move around with any equipment they used. Two people had information about how staff should support them with their memory and communication needs. Some people had information about their likes and dislikes in relation to food. However, as demonstrated above this information was not sufficiently detailed to ensure people received person-centred care that met their needs.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection on 4 and 5 August 2016 we found a breach of the regulations in relation to good governance. The provider had systems in place to assess the quality of the service and had put in place action plans to address the shortfalls they found, but these were not always effective as the action they took was not adequate to meet the required standards or did not happen within an appropriate timescale.

At this inspection, the registered manager told us they were taking action to address all of the issues we found at our last inspection although they had placed a higher priority on medicines management as they felt this was the largest area of concern. We saw evidence that most staff had received extra training and supervision about medicines management and record keeping. The manager told us they had introduced leadership roles in medicines management for some staff so they could carry out more medicines audits. We saw examples of training materials given to staff including fact sheets about the importance of completing medicines administration records (MARs) correctly.

The registered manager told us their records audits showed that since they introduced themed record keeping supervision, the number of mistakes in care records had reduced significantly. We saw that in five out of six cases, records audits had identified gaps in MARs and action had been taken or planned, such as extra supervision, training or investigations. Senior managers visited the service approximately once a week to carry out quality checks and support the registered manager with making improvements and the provider also carried out regular audits. We found that four separate audits and checks carried out by the provider in January and February 2017 had identified the same concerns we found, including a lack of personalisation and detail in care plans about the care people required and about their medical conditions and also that some medicines records and repositioning charts were not completed correctly.

However, the evidence we found at this inspection demonstrated that although the provider continued to use appropriate systems to identify shortfalls in the quality of the service, the measures they took to rectify these were still not effective. We did not find significant improvements from our last inspection in terms of safe care and treatment or person-centred care. Additionally, one log book audit had failed to identify significant problems with incorrect or missing medicines records.

The provider continued to be in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Notwithstanding the above, we also noted that the quality of care records in general had improved since our last inspection with staff recording more accurately their times of arrival and departure at people's homes and there was more detail in care notes. This meant it was easier to identify whether people received their care as planned.

We saw evidence that each of the six people whose records we reviewed had received a quality assurance visit since they started using the service and four had also received structured telephone interviews to check whether they were satisfied with the service. The provider used the visits to observe the quality of care and

speak to people about their views of the service they received. Records we saw indicated that people were happy with the service and the staff who delivered their care with two people commenting that they felt the service had improved significantly over the last year. We also saw evidence that the provider had invited people in November 2016 to come to the office for tea and cake, to meet the office staff and give feedback if they wished to do so.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users did not meet their needs and reflect their preferences. This was because the registered person did not design care and treatment in such a way as to achieve service users' preference and ensure their needs were met. Regulation 9 (1)(3)(b)

The enforcement action we took:

We served a warning notice against the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not assess the risks to the health and safety of service users and do all that was reasonably practicable to mitigate such risks. They did not ensure the proper and safe management of medicines took place. Regulation 12 (1)(2)(a)(b)(g)

The enforcement action we took:

We served a warning notice against the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not operated effectively in terms of improving the quality and safety of services provided and mitigating risks which arise from the carrying on of the regulated activity. The provider did not maintain an accurate, complete and contemporaneous record of the care and treatment provided to each service user. Regulation 17 (1)(2)(a)(b)(c)(f)

The enforcement action we took:

We served a warning notice against the provider.