Eleanor Nursing and Social Care Limited

Eleanor Nursing & Social Care Ltd - Lewisham Office

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	**Inspected but not rated**

Summary of findings

Overall summary

Eleanor Nursing & Social Care Ltd - Lewisham Office is a domiciliary care agency. It provides personal care for people living in their own houses and flats in the community. It provides a service to older adults and younger disabled adults. At the time of the inspection the service was supporting 383 people.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
Medicines were not always been managed safely but there were improvements since the last inspection. The provider's audits were not always identifying errors in people's medicine administration records (MARS). We made a recommendation to the provider to ensure there were effective processes in place for medicines management.

Care workers had completed in-house training on how to administer medicines safely and appropriately with refresher courses every year which included a competency assessment.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made and the provider was no longer in breach of regulations. We did however make a recommendation to the provider to ensure there were effective processes in place for medicines management.

Why we inspected
We undertook this targeted inspection to check whether the provider was still in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. The overall rating for the service has not changed following this targeted inspection and remains good.

CQC have introduced targeted inspections to follow up on breaches or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

Follow up

We will continue to monitor information we receive about the service. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

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Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check whether the provider was still in breach of regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspection team
The inspection was carried out by one inspector.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced. We gave the provider 24 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We looked at a range of records regarding medicine management. We spoke with a senior care coordinator, an operations manager and the nominated individual. The nominated individual is responsible for supervising the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inspected but not rated

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question, we had specific concerns about.

The purpose of this inspection was to check improvements had been made and that the provider was no longer in breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection the provider had failed to ensure the safe management of medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvements had been made at this inspection and the provider is no longer in breach of regulation 12.

- Medicines were not always been managed safely. At the last inspection, the provider's audits were not always identifying medicine errors. Improvements had been made to the auditing process, but we continued to identify minor gaps in some audits. For example, two of the eight audits did not always pick up when people missed their medicine.
- In cases where errors were found there was a lack of recording when follow up action was required. This meant there were no processes in place to ensure follow up work was completed. We raised this with senior staff, and they recognised that improvements still needed to be made.
- Medicines records had been filled out correctly, but the provider was still using different medicine codes which increased the opportunities for inaccurate recording.

We recommend the provider review their audits to ensure there are effective processes in place for medicine management.

- The provider had implemented clear recording systems to ensure staff had the correct information to mitigate potential risks.
- We reviewed the medicine administration records (MAR) charts for eight people and saw information on the types of medicines prescribed, the dosage and frequency and how the medicine should be administered. If people had allergies this was also recorded. This told us care workers had the correct information to administer medicines safely.
- The provider had effective risk assessments in place for people who were using emollient based creams.
- Care workers had completed in-house training on how to administer medicines safely and appropriately with refresher courses every year which included a competency assessment.

- People on time specific medicines received their medicines as prescribed.