Three Sisters Care Ltd

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Inspection report

St Georges Town Hall
236 Cable Street
London
E1 0BL

Tel: 02077906057

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25 April 2017
15 May 2017

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**

Summary of findings

Overall summary

We had conducted an announced comprehensive inspection of this service on 22 June 2016. Breaches of legal requirements had been found, which included safe management of medicines and support of staff, in regards to staff supervision and training. Following the inspection, the provider wrote to us to state what actions they would take in order to meet the legal requirements in relation to the breaches. We subsequently had carried out a focused inspection on 14 February 2017 to check the provider had followed their plan and to confirm that they had met legal requirements. We had found that although some improvements had been achieved, the provider had not satisfactorily met the breaches for safe management of medicines and support of staff. It was noted that although staff now received appropriate supervision, there were shortfalls in terms of staff receiving suitable training to meet people's needs. We had issued two Warning Notices for the two breaches of legal requirements and received an action plan from the provider to explain how they would address the issues within the Warning Notices.

This focused inspection was undertaken on 25 April and 15 May 2017 to check that the provider had adhered to their action plan and to establish if they now met legal requirements. We gave the provider short notice of our intention to conduct this inspection, as we needed to ensure that key staff would be available to access the information we required. This report only covers our findings in relation to safe management of medicines and support of staff. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Three Sisters Care Ltd on our website at www.cqc.org.uk.

Three Sisters Care Ltd is a domiciliary care agency located in the London Borough of Tower Hamlets. The agency provided personal care to people living within the borough and other London boroughs. At the time of the inspection 145 people were receiving personal care services; however, there was a structured plan in place for the agency to steadily increase the number of people using its services in line with new commissioning arrangements within Tower Hamlets.

There was a 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 registered manager was present during this inspection.

At this inspection we found that the provider had achieved significant improvements. There were systems in place to ensure that the provider had clearly documented and up to date records in relation to people's medicine needs. Staff had received medicines training and the staff we spoke with understood how to safely support people to take their prescribed medicines. The registered manager audited people's medicine administration records every month and staff's ability to adhere to the provider's medicines policy and procedures was monitored by field supervisors during 'spot check' visits at people's homes.

The gaps in staff training had been addressed and there was a robust structure in place to ensure that staff

adhered to the provider's training programme. Care staff told us that the management team and senior staff highlighted the necessity to attend mandatory training during their one to one supervision meetings and staff meetings. We received complimentary comments about the quality of the training from staff, and people who used the service and relatives remarked that staff appeared to be suitably prepared and trained for their duties. The provider showed us the plans they had developed in order to ensure that staff transferred from other agencies received an appropriate induction to the values of their new employer in addition to a mandatory training programme.

Following this inspection, we concluded that the provider had met the legal requirements of the two Warning Notices.

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

Safe was rated as requires improvement at the previous inspection.

Thorough practices had been put into effect to ensure that people were safely supported with their medicines.

We will review our rating for safe at the next comprehensive inspection. While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice and we did not cover all aspects of the key question.

Is the service effective?

Requires Improvement

Effective was rated as requires improvement at the previous inspection.

Staff were supported to effectively meet people's needs through a well organised training package, as well as support through individual and group meetings, and spot check visits to assess their practice.

We will review our rating for effective at the next comprehensive inspection. While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice and we did not cover all aspects of the key question.

Three Sisters Care Ltd

Detailed findings

Background to this inspection

We carried out a focused inspection of Three Sisters Care Limited on 25 April and 15 May 2017. The inspection was unannounced on the first day and we gave the provider short notice on the day before we commenced. This was because senior staff at domiciliary care agencies are sometimes out of the office supporting people who use the service and staff. We informed the provider of our intention to return on the second day, in order to provide feedback following our telephone calls to people who use the service and care staff. The inspection was undertaken to check that improvements to meet legal requirements planned by the provider after our previous inspection on 14 February 2017 had been implemented.

We inspected the service against two out of five questions we ask about services: Is the service safe and is the service effective? The inspection team consisted of one adult social care inspector and a pharmacist inspection manager on the first day and one adult social care inspector on the second day. During the inspection we spoke with one care worker, the registered manager and the director. We looked at a range of records including eight people's care plans with the accompanying medicine administration records, staff training records, the provider's training matrix, and policies and procedures in regards to safe medicine management and staff training and development.

Following the inspection we spoke by telephone with two people who used the service, the relatives of three other people and five care workers. We contacted one health and social care professional for their views about the quality of the service and did not receive any comments.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection we had found that the provider was not managing medicines in a safe manner. Risk assessments had been carried out, and records of medicines administration were being checked by the manager, however we found that records were not accurately completed and did not always reflect people's current medicines. Staff had received training in administering medicines, but the provider had not carried out observations of staff to ensure they were competent to do this. These issues in relation to the safe management of medicines resulted in us issuing a Warning Notice to the provider, which was due to be met by 26 March 2017.

At this inspection we found that improvements had been made. We looked at the records for eight people who were supported to take medicines by the service. Each person had a risk assessment and current list of medicines in their file. We saw one file where the medicines had changed and the provider had made significant efforts to obtain confirmation of the new information, although they had not yet been successful. We saw that where people had been discharged from hospital a record of their discharge prescription was in their record. Medication administration records (MAR) were accurate and completed by care staff in people's homes. These were returned to the service for checking. We saw that the registered manager checked the MAR and any actions were followed up; for example we saw that a temporary written MAR was replaced by a printed one to ensure accuracy. We spoke with a care worker who told us that if they made any mistakes in the records, their manager would go through it with them to make sure that people had been given their medicines correctly. The care plans were reviewed regularly and the medicines information updated. We saw where one medicine had been stopped by the person's GP and the record was changed to reflect this.

All care workers who administered medicines had been trained in safe medicines handling; the service was currently training all staff to the same standard. We saw records of competency assessments and observations that had been done for some staff and were being rolled out to the rest. At the inspection we spoke with one care worker who described how they supported people to take their medicines safely in a caring and individual manner. Following the first day of the inspection, we spoke by telephone with five care workers in regards to their understanding of how to correctly support people with their medicines. Staff informed us they had received medicines training and explained the careful actions they took in order to ensure people received their medicines in accordance with the provider's policies and written guidance. People who used the service, and relatives where applicable, told us they were pleased with how staff provided support to prompt or assist with medicines.

The registered manager carried out monthly audits of the care plans and the medication plans. We looked at the ones for March 2017 and saw that they were comprehensive and effective. Actions were taken immediately where needed, for example we saw that one family had been contacted to provide further information about a person's medicines which had then been entered into the person's record.

We will review our rating for safe at the next comprehensive inspection. While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice and we did not cover all aspects of the key question.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection we had found that the provider had not ensured that all staff had received training in a range of health and social care topics including first aid, health and safety, fire safety, infection control, safeguarding adults and manual handling. We had found gaps in the staff training matrix which demonstrated that some staff had not completed training in accordance with the provider's mandatory training policy. These issues in relation to staff training resulted in us issuing a Warning Notice to the provider, which was due to be met by 27 March 2017.

At this inspection we found that improvements had been made. We looked at staff training records, the training matrix and the provider's plan to ensure that staff transferring from other providers promptly received their mandatory training. We noted that the vast majority of staff had now attended their required training courses and any gaps in training were due to exceptional reasons, for example if an employee was on a period of authorised leave. In these circumstances, arrangements were in place to accommodate staff on forthcoming planned training dates.

The registered manager showed us how she audited training records to identify when staff needed mandatory and refresher training. We noted from the minutes for staff meetings that the registered manager spoke with staff about the importance of attending training and potential disciplinary measures that could be implemented if employees failed to comply with their training schedule within agreed timescales, unless there was a valid explanation.

People who used the service and relatives stated that their allocated care workers presented as being knowledgeable, competent and efficient. One relative told us, "[My family member's] regular care worker understands how to do things the way he/she like and knows that sometimes [my family member] need more help in the mornings because [medical condition] varies." The care workers we spoke with informed us they enjoyed the provider's training programme and found it useful. We spoke with care staff in regards to a range of personal care themes which included how to provide care and support that reflected people's diverse cultural needs, how to maintain people's dignity and how to support people who could not verbally express their wishes and preferences. Staff told us their training and on-going support from the provider covered these issues and gave us accounts from their current or recent practice as to how they understood and met people's different needs.

We will review our rating for effective at the next comprehensive inspection. While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice and we did not cover all aspects of the key question.