Admiral Care Ltd

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Inspection report

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Date of inspection visit:
16 May 2017

Date of publication:
16 June 2017

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 this service on 2, 3 and 4 November 2016. We found two breaches of regulations relating to records and the safe management of medicines. We gave the service an overall rating of requires improvement and told the provider to send us a report by 7 March 2017 of actions they proposed to take.

We undertook this focused inspection to check whether the provider had taken action and to confirm whether they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the "all reports" link for Admiral Care Limited on our web site at www.cqc.org.uk.

This focused inspection took place on 16 May 2017. We gave the provider 24 hours' notice so that people we needed to speak with would be available.

The previous comprehensive inspection found the provider was not meeting the requirements of regulations concerning the safe management of medicines and maintaining up to date records. This inspection found that improvements had been made in both areas. The provider was now meeting the requirements of the regulations. However there were still areas where improvements could be made with respect to people's medicines records and the provider had not sent us a report of actions when requested. The rating for the service therefore remains requires improvement.

Admiral Care Limited provides personal care to people in their own homes. At the time of this inspection the service provided personal care to 80 people with a range of needs including people living with dementia, older people, and people with a physical disability. Admiral Care Limited also provides services to people which are outside the Care Quality Commission's regulatory remit.

The service had a registered manager in place. A registered manager is a person who has registered with us 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 provider had taken steps to improve the consistency and clarity of records relating to people's medicines. Where people had complex needs the registered manager only assigned experienced care workers who knew the person and understood their needs to call on them.

The provider had put in place processes and procedures to make sure records relating to people's care and support were kept accurate and up to date.

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 always safe.

People were protected against the risks associated with medicines because relevant records were clear and consistent. However there were still out of date records in one person's file and another person's records could be improved with more detailed instructions.

Is the service well-led?

Requires Improvement

The service was not always well led.

People were protected against the risk of poor or inappropriate care because processes were in place to make sure records were up to date and accurate. However the provider had failed to send us a report of actions when requested to do so.

Admiral Care Limited

Detailed findings

Background to this inspection

We undertook this focused inspection of Admiral Care Limited on 16 May 2017. We gave the service 24 hours' notice of our visit to make sure people we needed to speak with would be available. The purpose of this inspection was to check that necessary improvements had been made since our last comprehensive inspection on 2, 3 and 4 November 2016. At the previous inspection we identified breaches of two regulations and required the provider to send us a report of actions they planned to take to become compliant with those regulations.

A single inspector carried out this inspection, which only looked at the areas where we had previously identified concerns. These were the safe management of medicines and the maintenance of accurate, up to date records relating to people's care and support.

During the inspection we spoke with the registered manager, the deputy manager and a member of staff. We looked at the care plans and associated records of six people. Three of these people had started to receive personal care services since our last inspection. We also looked at records relating to safeguarding incidents, and the provider's improvement action plans. On this occasion we did not speak with people who used the service or their representatives, because our concerns related to the management and accuracy of records.

Before the inspection we reviewed information we had about the service, including previous inspection reports, information from members of the public, and notifications the provider had sent to us. A notification is information about important events which the provider is required to tell us about by law.

Requires Improvement

Is the service safe?

Our findings

At our comprehensive inspection of Admiral Care Limited on 2, 3 and 4 November 2016 we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not made sure that people received safe care and treatment by means of the safe management of medicines. Some people's care plans contained contradictory information about medicines which meant people were at risk of not receiving their medicines as prescribed. We required the provider to send us a report of actions they intended to take to become compliant with this regulation.

Although we did not receive the requested report, at this inspection we found that improvements had been made and the provider was no longer in breach of the regulation.

In four of six care files we looked at, records relating to medicines were clear, consistent and up to date. Care workers had instructions and guidance which allowed them to support people with their medicines as prescribed and according to people's preferences.

The office files for the other two people contained out of date information. In one, a "client profile form" dated 27 January 2016 stated under "duties required" that care workers should assist with medicines during the person's morning call. The person's care plan dated 2 December 2016 stated that the person's representative would administer the person's morning medicines. The registered manager told us the care plan was correct, and that care workers referred to the care plan in the person's home. The client profile form, which documented an initial assessment of the person's needs was not part of the file in the person's home. Other records we saw supported this. Although there was a discrepancy between the person's initial assessment and their current care plan, they were receiving care which met their needs.

We discussed this person's medicines care plan with the registered manager. Responsibility for the person's medicines varied with the time of day. Their representative took care of their morning medicines, while care workers administered medicines at other times. The manager agreed that where medicines were administered at certain times of the day by a person not employed by the service this introduced an additional risk. The care plan could be improved by more detail about how care workers should check what medicines had already been taken and how to communicate with other people responsible for the person's medicines.

The other person's office file contained two out of date "administration of drugs consent forms". The care file normally kept in the person's home had been returned to the office for review and update on the day of our visit. We could see that these out of date forms were not present in the care file used on a day to day basis. The registered manager agreed they should be archived from the office file as they referred to medicines no longer in the person's prescription. The method by which this person preferred to take their medicines had changed, and their care file was in the office so the necessary changes could be made. Although there were still contradictory records in this person's file, the manager took steps to correct this, and they were confident the person was receiving their medicines according to their needs and preferences.

Both these people had more complex needs than others whose records we looked at. The registered manager had taken steps to reduce the risks associated with their medicines. These included only assigning experienced staff who knew the people well to call on them, and engaging with the person and their family or other representatives. We noted both people had capacity to consent to their care and communicate their preferences and wishes.

Where a concern had been raised that a person might not have received the correct medicines at the correct time, there had been a thorough investigation undertaken at the request of the local safeguarding authority. The investigator had obtained statements from care workers and the person's representative, and reviewed records. However the evidence whether an error had been made was inconclusive. It was therefore not possible to conclude that the person's care and treatment had been unsafe. The provider had reviewed and updated the person's medicines care plans after the conclusion of the investigation.

Where we identified areas for improvement of records, the impact on people was low and steps were taken to reduce the risk to them arising from the management of medicines.

Requires Improvement

Is the service well-led?

Our findings

At our comprehensive inspection of Admiral Care Limited on 2, 3 and 4 November 2016 we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not maintained up to date and accurate records relating to people's care and support. People's care plans did not always reflect their changing needs and circumstances. We required the provider to send us a report of actions they intended to take to become compliant with this regulation.

We did not receive the requested report, however at this inspection we found that improvements had been made and the provider was no longer in breach of the regulation with respect to records.

The registered manager was not able to find evidence during our visit or the days following that the report had been sent to us. They attributed this to a change of personnel responsible for this since our previous inspection. This meant the provider had failed to meet a legal obligation to send us their improvement plan when requested. However we saw the provider's improvement action plan had been updated following our previous inspection to include the areas of concern we identified. It had been updated in subsequent months to reflect progress made.

Records showed people's care files were checked every month. A nominated staff member was responsible for this under the supervision of the deputy manager. These checks included the service contract, mental capacity assessments, care plan reviews, risk assessments in place, incidents reported with body maps if appropriate, and care diaries completed legibly. The care files kept in people's homes were brought in to the office every three months for a review.

The six care files we looked at were up to date or in the process of being updated, although one contained some out of date records which should be archived. Care plans contained clear instructions for care workers which took into account people's preferences and wishes. Care diaries were checked regularly and sample pages were retained in the person's file to show this had been done. There were up to date logs of contacts with people's families and other professionals involved in their care. The provider had introduced new forms for recording people's medicines and for documenting assessments of people's mental capacity.

The provider had failed to send us their plan of actions, but they had taken steps to improve people's care records and had put in a place a process to keep them up to date and identify any changes required. This had reduced the risk to people of receiving incorrect or inappropriate care or support.