BGS Healthcare Ltd

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Inspection report

The Stables
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Date of inspection visit:
08 July 2020
13 July 2020
20 July 2020

Date of publication:
11 August 2020

Ratings

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

Summary of findings

Overall summary

About the service
BGS Healthcare Ltd is a domiciliary care service providing personal care to people living in their own homes and flats. At the time of this inspection there were 97 people receiving a service.

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
People did not always have their medicines as prescribed. People's medicines administration records had not always been accurately recorded which had led to medicines errors. The provider informed us they had changed their methods of working and had put in place systems to check the accuracy of recording.

Where medicines errors had occurred there was limited evidence of analysis or learning. The provider audited medicines and had action plans for improvement in some areas but it was limited and did not consider all factors.

Staff had been trained to administer medicines but had not always had their skills checked for competence in all areas. For example, most of the staff applied topical creams for people. Application of creams had not always been demonstrated or checked by the provider.

The provider had policies for medicines but limited procedures. This meant the staff were not following clear procedures on how to administer medicines safely. Whilst staff could call the office at any time if they were unsure, procedures guide the staff as to how to administer all types of medicines safely.

Despite the shortfalls we have found, people were happy with the support they had from staff to administer their medicines. They felt the staff were competent and helpful. Staff told us they felt competent and were able to ask at the office if they were unsure of anything.

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 last rating for this service was Requires Improvement (published 22 August 2019). Following that inspection the provider completed an action plan to show what they would do and by when to improve.

At this inspection enough improvement had not been made and the provider was still in breach of regulation.

Why we inspected

We undertook this targeted inspection to check on a specific concern we had about medicines management following a serious medicines error. The overall rating for the service has not changed following this targeted inspection and remains Requires Improvement.

CQC have introduced targeted inspections to follow up on Warning Notices 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.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified a continued breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014 in relation to medicines management and management oversight at this inspection. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit to check improvement has been made. 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.

BGS Healthcare Ltd

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check on a specific concern we had about medicines management following a serious medicines error.

Inspection team
This inspection was carried out by an inspector and a medicines inspector.

Service and service type
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
We gave the service 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.

Inspection activity started on 8 July 2020 and ended on 20 July 2020. We visited the office location on 8 July 2020.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. 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 spoke with five people who used the service and three relatives about their experiences of the care

provided. We spoke with seven members of staff, the registered manager and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 12 people's medicines records, records about medicines incidents, medicines related policies and procedures and staff training records.

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 comprehensive inspection in May 2019 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.

Following that inspection, we served a warning notice to the provider for a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014 (Safe Care and Treatment) due to concerns medicines were not being managed safely. We issued a requirement notice for a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014 (Good governance) for concerns about management oversight which included medicines management. We carried out a targeted inspection in November 2019 to check for compliance with the warning notice. We found the service had met the requirements but further improvement was needed with medicines governance.

The purpose of this inspection was to check a specific concern we had about medicines management following a serious medicines error. We will assess all of the key question at the next comprehensive inspection of the service.

Using medicines safely; Learning lessons when things go wrong

- People who had been prescribed medicine to be given using a patch did not have a record for staff to know where on the body the patch had been applied. If staff do not record where on the person's body they apply a patch it increases the risk of error and skin irritation. The provider told us they would introduce a record for staff to use to record the application of patches.
- People's medicines administration records were not always clearly updated with changes. This had contributed to two medicines errors. For example, for one person we saw the service had taken responsibility for ordering their medicines. Poor record keeping had led to them not receiving their pain-relieving medicines in a timely way. National Institute for Health and Care Excellence (NICE) guidelines state that providers should ensure records are 'accurate and kept up to date'.
- Systems were not in place to check the accuracy of transcribing medicines information onto the providers electronic system. One member of staff had been allocated to carry out this task. The provider did not have a system to ensure the information they recorded was accurate. This had led to a medicines error. The provider told us following the error they had introduced a system so that two members of staff would check the information and recording.
- There were systems in place to report any medicines errors or incidents. Regular medicines audits were completed, and we saw that some issues were identified, and actions for improvement recorded. However, there was no evidence of analysis of medicines errors and a review of what had happened and why. There was no evidence of reflective practice for the staff and opportunity to reflect on what they could do to prevent re-occurrence.
- Staff had been given medicines training which was a blend of a knowledge workbook and a face to face session. Competence to administer medicines had been carried out at the office but were knowledge based.

This meant the provider could not be sure all the staff were following safe procedures as they had not checked staff skills to administer medicines safely.

● Whilst staff told us they had training on how to administer medicines they had not all been shown how to apply topical creams or eye drops. There had also been no competency checks for this type of medicines administration.

● The provider shared their medicines policies with us. Whilst they had policies in place for a variety of medicines related areas there were no clear procedures for administering all types of medicines. The provider had procedures for administering eye drops and ear drops but no other type of medicine. Procedures give the staff a clear guide on how to administer all types of medicines safely.

Failing to make sure systems and records were in place and effective to mitigate and manage risk of harm is a continued breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● People and relatives were happy with the support they had from the service and the help with their medicines. Comments included, "I am happy with everything they do for [person], no issues with medicines. The staff have been great, I am happy with them", "Staff seem to be well trained, they all seem to be sure of what they are doing", "One lady came from the office to check what they were doing. I have no concerns about the service, I don't know where I would be without them" and "I have no complaints, the staff have the skills they need. They do my medicines in a competent way."

● People's medicines administration records had details about the levels of support the person needed and identified if they had any allergies.

● If people were prescribed topical creams there were body maps in place to guide staff on where to apply the cream and when.

● All the staff we spoke with told us they felt competent to administer people's medicines and they had been given the training they needed. Comments from the staff included, "I have had medicines training. I only prompt people usually. We always ask them [people] first if they want their medicines, if not we don't take them out of the box", "I feel competent to administer medicines, I can always ask for help or advice if I need to" and "I have had full training, the office won't send me to people I have not had training for."

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 17 HSCA RA Regulations 2014 Good governance The provider had failed to have robust and effective management systems in place to ensure medicines were safely managed.

The enforcement action we took:

We served a warning notice.