BGS Healthcare Ltd

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Inspection report

The Stables
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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 provider providing personal care to 104 people at the time of our inspection.

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's medicines were managed, administered and disposed of safely. Improvements had been made to the management, recording and support people received with their medicines.
The service worked well with other professionals to ensure people had their prescribed medicines.
People were supported by staff who were trained in medicines management and had been observed administering medicines to ensure they were following safe practices. Staff told us they were confident managing medicines.
The registered manager had good oversight on the management of medicines, there were a number of effective quality assurance protocols in place to ensure medicines were consistently managed safely
There were clear policies and procedures in place to support the safe administration of medicines.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection
The last rating for this service was requires improvement (published 22 August 2019). There were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve.
We completed a targeted inspection on 8 July 2020, this inspection was prompted in part due to concerns received about medicines management. A decision was made for us to inspect and examine those risks.
Following our last inspection, we served a warning notice on the provider and the registered manager. We required them to be compliant with Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014 by 04 September 2020. At this inspection we found enough improvements had been made to meet the warning notice.

Why we inspected

We undertook this targeted inspection to check whether the Warning Notice we previously served in relation to Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. 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.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. 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 whether the provider had met the requirements of the Warning Notice in relation to Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Inspection team
This inspection was carried out by two inspectors.

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 it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before the inspection
We reviewed the information we had received about the service since the last inspection, this included feedback from professionals working with the service and notifications sent to us by the provider. Notifications are information about specific incidents the service is required to tell us about. This information helps support our inspections. We used all of this information to plan our inspection.
During the inspection
During this inspection, we spoke with nine staff, this included care staff, office staff, the registered manager and the 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 10 peoples medicine care plans and related medicine records. Records about medicine incidents, medicine 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 on 16 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.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served. We will assess all of the key question at the next comprehensive inspection of the service.

During this is inspection, we found enough improvements had been made to meet the requirements of the warning notice.

Using medicines safely
• People's medicines were managed safely. Actions had been taken to address previous concerns, and improvements made to the management, recording and support people received with their medicines.
• The service used an electronic system to record and monitor the administration and management of people's medicines. This enabled the provider to have clearer oversight over any issues and take timely action to address these.
• The provider had implemented a system to second check medicines when they were transcribed. This reduced the risk for error when creating medicines records on the medicines management system.
• Staff supported people to stay as independent as possible, for example, one person received support for only one part of the administration process, this was set to be reviewed in six months. This demonstrated the service was working with people and were mindful to maintain people's independence.
• Where people were prescribed medicines to take as required [PRN], information was recorded on the administration medicine record for staff to see. We saw the information recorded was clear, and detailed what staff needed to know when administering these medicines to people.
• Where medicine was administered via transdermal patch, information was recorded on the location it was removed from, and where a new one was positioned on a person's body. This meant the risk of placing them in the same position was safely managed.
• Where medicine errors had occurred, a reflective meeting was held with the staff member concerned. If required, further medicines training was provided. We saw that staff had the opportunity to reflect on what they would have done differently and identify any support they needed going forward to mitigate any future reoccurrences. Staff were aware of the procedures to follow if they identified a medicines error. This included seeking medical advice, informing the office and updating the person's records on their electronic system.
• Staff had received training in medicines and been observed administering medicines to ensure they were following safe practices. Staff spoke confidently about providing medicines support to people commenting, "I have no concerns, I feel confident and BGS kept making sure I was happy first before I went out to administer medicines" and "I have been observed by the [registered] manager and a letter was sent out to

us following this. It's nice to get some feedback and recognition."
• The service worked collaboratively with healthcare professionals to support people in a way that worked for them. We saw, one person's medicine plan recorded that they understood about their medicines and the importance of taking them. However, this person had not taken them on one occasion. The service contacted the GP and they worked collaboratively to change the times so staff were visiting when administration was needed. A risk assessment was put in place to ensure staff were aware to check if medicine had been taken and take action if not.
• Quality assurance systems were in place to ensure the provider had good oversight over the management of medicines. Any concerns identified were addressed promptly and appropriately.
• The registered manager analysed trends in data from the medicines management system monthly, this enabled them to identify patterns and implement improvements. This analysis was shared with care staff in a newsletter.
• There were clear policies and procedures in place to support the safe administration of medicines, this included a general policy as well as policies covering transdermal patches, topical medicines, safe storage and cultural considerations.