Givecare

Bosworth Homecare Administrative Offices

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Bosworth Homecare Administrative Offices is a domiciliary care agency providing the regulated activity personal care to people living in their own homes. At the time of our inspection there were 139 people using the 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
Care plans and risk assessments were not regularly reviewed. Health specific care plans and risk assessments were not in place. This meant staff did not always have information and guidance available to them to safely monitor need and respond to risk.

Staff administered medicines but we found some instances where practice was not always safe.

Improvements had been made to staffing levels, however staff did not always stay for the length of time they should at care calls.

Systems and processes were not effectively used to ensure the service ran efficiently and safely all of the time.

The service did not have a registered manager. A new acting manager was in post who was working hard to make improvements at the service and promote positive changes.

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 good (published 25 May 2019).

Why we inspected
We received concerns in relation to care calls being delivered late or missed; staffing levels and poor management oversight. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of

this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bosworth Homecare Administrative Offices on our website at www.cqc.org.uk.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to how people received safe care and treatment, and how the service was managed 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Bosworth Homecare Administrative Offices

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was carried out by two inspectors.
Three Expert by Experiences made telephone calls to people using the service and their relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
We gave the service 48 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.

Inspection activity started on 17 March 2022 and ended on 21 June 2022. The date range for the inspection was wide due to changes in the inspection team. We visited the location's office on 31 May 2022 and 1 June 2022.

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 who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with eight members of staff including the operations manager, manager, compliance officer, care co-ordinator and carers. We reviewed five care plans and risk assessments of people using the service and medicine administration records.

We reviewed five staff files, and also a variety of policies, procedures and documents. We spoke with 23 people using the service and 21 relatives of people to understand their experiences.
Following the inspection, we continued to seek clarification from the provider to validate our findings.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm

Assessing risk, safety monitoring and management

- People did not have health specific risk assessments in place. For example, people with Diabetes and Parkinson's Disease did not have care plans and risk assessments. Staff did not have information and guidance about how to monitor and manage people's health conditions appropriately. This meant people were exposed to unnecessary risk and avoidable harm.
- Assessments of risk and safety had not been regularly undertaken. The manager had worked hard to review and re-assess people's needs, but information available to staff was not always current. This meant staff did not always have information about people's care needs and associated risks. This may have exposed people to the unnecessary risk of avoidable harm.
- Actions to monitor risk were not always taken. We found instances where staff had identified changes to people's health, but there was not clear evidence to suggest follow up actions had been taken. This meant we were not always assured staff reported concerns and dealt with them accordingly.

Staffing and recruitment

- Care call times differed. People told us calls were not always provided at the times they needed. This impacted one person who's relative told us, "We are not happy with the time they come because [person's name] has to have his medication at a certain time." This may have impacted detrimentally upon the person's health and led to avoidable harm.
- Staff did not always stay the full call time. People's experiences of staff visiting them varied. One person told us, "Not many carers stay for the full half hour." A relative told us, "We pay for 30 minutes of care, neighbours have timed them [staff] and they've been there anything from 8 minutes to 20 minutes." Other people however were happy with the care calls being delivered. One person told us, "Staff always stay for the full half an hour call but will stay longer if they need to." Systems to monitor call times were not effectively used.
- There had not always been enough staff. The COVID-19 pandemic had impacted staffing levels, and the manager acknowledged there had been points when there were not enough staff to deliver safe care. The manager was continually recruiting staff to try and ensure numbers were adequate to provide safe care

The provider failed to ensure people received safe care and treatment. People did not always have their care needs risk assessed and staff did not always provide care calls as required. This placed people at risk of harm. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Improvements to staffing consistency had been made. People told us they were supported by regular

staff, but most people did not receive rotas to inform them of who would be coming to their homes. One person told us, "I haven't got a rota. I don't know who is coming until they come."
● Staff received training. Staff told us they had received comprehensive training that prepared them to carry out their roles. One staff member told us, "The training programme is above and beyond what I've had before."
● Staff were recruited safely. We reviewed five staff files and found necessary checks including a Disclosure and Barring Service (DBS) check had taken place before staff started work. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely
● Some medicine practices were not safe. We found staff were leaving medicines out for staff to administer later in the day or the next day for one person. This meant there was a risk medicines could be given incorrectly, which could expose the person to unnecessary risk of harm.
● Information regarding medicine management was not always available. We reviewed people's care files and found not all people had care plans or risk assessments for medicines. One person required time critical medicines for Parkinson's Disease, but there was limited guidance in place for staff to follow. This meant staff did not have all relevant information required to safely administer medicines which may have exposed people to unnecessary and avoidable risk of harm.

Systems and processes to safeguard people from the risk of abuse
● People were not always safeguarded. Systems and processes were not effectively used to monitor and manage safeguarding concerns. While staff understood what safeguarding concerns may be, records were not consistently in place to evidence safeguarding concerns were always investigated and reported accordingly. We could not be assured people had always been safeguarded from the risk of abuse.
● People felt safe. People and their relatives felt staff helped to keep them safe in their homes. One person told us, "The carers make me feel safe, they support me, care for me." Another person told us, "The carers are wonderful, and I feel safe knowing that someone is coming into my home every day."

Learning lessons when things go wrong
● Lessons were not learned. The provider had failed to ensure lessons were learned when things had gone wrong. Records were not kept. This meant examples of practice and ways to reduce the likelihood of incidents occurring were not identified or shared with staff. During the inspection the manager told us they would implement a document to record lessons learned.

Preventing and controlling infection
● Staff used personal protective equipment (PPE) in accordance with government guidance. People told us staff always wore PPE during their visits and washed their hands regularly. One person told us, "The carers all wear face masks, gloves and aprons. They have them all on before they come into the house." This helped to reduce the risk of contracting and transmitting COVID-19 and other viruses.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The service was not always well-led. Staff had not been managed effectively while there was no registered manager. This meant people using the service experienced differences in how their care was provided. The manager in post had worked hard to make positive change with the staffing team to improve efficiency and safety at the service.
- There was limited oversight. Senior management support had been introduced to provide consistency, but it was ineffective. This meant people did not always receive safe care and treatment and may have been exposed to avoidable harm.
- Governance of the service was not effective. Systems in place to monitor the service and quality of care people received was not consistently or reliably used. For example, people's care files were reviewed, but concerns around safe medicine administration was not identified. This meant risks were not always recognised or managed which prevented the quality of care people received from being improved.
- The culture had not always been positive. There had been many staffing and management changes which impacted upon staff morale. The manager was working to change the culture and a staff member told us, "Things have really settled down now and I feel more secure, so I'm happy."

Systems and processes were not always effectively used to ensure the service was managed safely. This placed people at risk of harm. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff felt supported. Supervisions were being undertaken on a more frequent basis, as were team meetings. Staff felt supervisions were beneficial and they were able to raise any questions or concerns at these times.
- Information was shared openly by the provider. The manager was honest and transparent and understood the duty of candour. This meant concerns could be investigated and resolved with relevant partner agencies as they occurred.

Continuous learning and improving care

- There was not a focus on continuous learning or improvement. The provider had failed to put systems in place to support staff to learn from mistakes and share good practice. This meant opportunities to improve

the service were missed.
● Complaints were dealt with. Investigations into complaints and concerns were recorded and actions were taken accordingly.

Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Relationships with partner agencies were positive. Staff told us they worked collaboratively and openly with health and social care professionals to ensure people received joined up care and support.
● People felt listened to. Most people and their relatives were able to raise concerns and felt the management team responded to them. Staff had faith in the management team and felt their views were listened to.
● Engagement and communication with people was improving. The manager was working hard to positively change how people were involved in shaping their care. Information could be provided in different formats such as large print and braille. People's relatives were contacted when the person could not contribute their views independently. This meant people's diverse needs and differences were taken into account.

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 12 HSCA RA Regulations 2014 Safe care and treatment Care plans and risk assessments were not reflective of people's needs and specific health care plans were not in place. Staff did not always stay for the length of time people required. This meant there was a risk people did not always receive safe care and treatment.

The enforcement action we took:

Warning Notice served.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not effectively used to monitor the service and ensure people always received safe care and treatment. The provider did not have oversight of the service.

The enforcement action we took:

Warning notice served.