Ampi Limited

Bluebird Care (Tonbridge & Tunbridge Wells)

Inspection report

Office 23 a/b, Pipers Business Centre
220 Vale Road
Tonbridge
Kent
TN9 1SP

Tel: 01732373024
Website: www.bluebirdcare.co.uk

Date of inspection visit:
25 June 2018

Date of publication:
05 September 2018

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Bluebird Care (Tonbridge & Tonbridge Wells) is a domiciliary care agency. It provides personal care to people living in their own houses and flats and live in care for adults and older adults. At the time of this inspection there were 130 people receiving personal care and five people receiving live in care.

Our last inspection on 17 March 2017 was a focused inspection to check the service was meeting the legal requirements following a breach from the previous comprehensive inspection on 15 June 2016. The breach was in relation to medicines not being managed safely. At the focused inspection we found improvements had been made and the provider had met the legal requirements with regards to the management of medicines, however it remained as requires improvement in safe as we needed to see consistent good practice over time.

At this inspection we found that good practice with the management of medicines had been sustained. The service continued to support the rating of good overall and was rated good in each of the five questions we ask. There was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

At this inspection we found the service remained good. Why the service is rated good:

There were policies and systems in place to safeguard people, assess risks and manage them, and to manage people's medicines safely. There were enough suitably recruited and trained staff to meet people's needs. Whilst there was some feedback from people around concerns with staff being on time for their visits, the provider had acted to manage and improve this and had implemented effective electronic records systems, which monitored any missed or late calls.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Staff supported people to be as independent as possible and remain living in their own homes. People's needs were met, including support with eating and drinking and accessing healthcare. The provider ensured there were systems in place to ensure staff had the right training, qualifications, support and supervision to do their job.

The management team consisted of the director (owner), the operations manager, the care manager and the supervisors. This team promoted a caring and positive culture and were passionate about their roles which could be seen in practice. Staff protected people's privacy and dignity and people were consulted, informed and involved with their care. The provider offered complimentary outings for people and showed how they valued their staff through complimentary events, recognition of milestones and awards. For example, they celebrated when staff completed their probationary period, work anniversaries and promotions; and held care assistant of the month and year awards.

People, relatives and staff were engaged in the service. People could raise concerns and the provider managed complaints and feedback received from people and their relatives. The provider had systems in place to promote continuous learning. The provider had good oversight of the quality and safety of the service and risks. Regulatory requirements were understood and managed.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service has improved to Good.
Systems and processes were in place to protect people from abuse and avoidable harm.
People's medicines were managed and used safely.
There were sufficient staff available to keep people safe and meet their needs.
People were protected by the prevention and control of infection.
The management team learnt from incidents and accidents and made improvements as a result.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Good

The service remains Good.

Bluebird Care (Tonbridge & Tunbridge Wells)

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We conducted an announced comprehensive inspection on 25 June 2018. We gave the service 48 hours' notice of the inspection visit because the location provides a homecare service and we needed to be sure we could meet staff.

The inspection was undertaken by two inspectors. Before our inspection we reviewed the information we held about the service including two previous inspection reports. We looked at notifications which had been submitted to inform our inspection. A notification is information about important events which the provider is required to tell us about by law. We looked at the Provider Information Return. This is information we require providers to send us at least once annually to give us some key information about the service, what the service did well and improvements they planned to make. We looked at questionnaires completed by people, relatives, staff and community professionals which were mapped to our five key questions. We received feedback from one commissioner. We took this into account when we inspected the service and made the judgements in this report.

During the inspection we spoke to two care staff, one care supervisor, the care manager, the operations manager and the director. We displayed a poster in the registered office inviting feedback from people, relatives and staff. Following this inspection, we spoke with two people and three relatives.

We reviewed five people's care records. We looked at medicines records on the provider's electronic system. We viewed four staff recruitment files, staff induction, training and supervision records and a variety of records relating to the management of the service including staff rotas and quality audits.

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe. One person when asked if they felt safe with the support from their care staff said, "Yes I do, very much so". All relatives we spoke to thought their loved one was kept safe.

At the last focused inspection sufficient action had been taken to address concerns raised regarding the safe management of medicines. A new electronic management system had been introduced. Staff had received refresher training and the medicines management process had been reviewed. This inspection looked at the impact of these changes and found the electronic care records system was used to effectively monitor the safe management of medicines. A medication quality assurance tool was used to check staff's knowledge and understanding.

Safeguarding and whistleblowing policies were in place and worked in line with Local Authority safeguarding procedures. The provider had notified us of any concerns. Staff had received training and were able to tell us what they would do in the event of a safeguarding concern. Risks to people were assessed and the information was available in their electronic care records system used by all staff. This meant that care staff always had access to these documents on their phones and any updates to people's risk assessments and care plans were immediately available. The system was not being used for live in care therefore the care supervisor visited and audited the service provided to these people weekly. Appropriate systems were in place which ensured information held about people was secure.

There were sufficient staff available to meet people's needs. Feedback around care staff arriving on time for care visits and therefore being able to stay for the duration of their visit was varied. One person when asked if staff had the time to support them without them feeling rushed, said "Oh yes they do, that's all right". One relative described how some staff arrived on time and others did not; that some got held up in traffic and some had too far to travel in between calls. When asked if their relative was given the time needed without them feeling rushed, the same relative said, "Most of them do, some rush in. Some have a little chat with (the person). One or two really cheer (the person) up and have a laugh with (the person)". One relative described how they were concerned that there was not enough time between visits to allow meals to be spaced. They told us how they had spoken to the manager about this, who said they would reschedule the calls, which they did.

The electronic care records system ensured that people were safeguarded from missed visits and received the care they needed. The manager explained to us how their rostering system prevented calls without travel time being scheduled and used a map navigation tool to calculate travelling time. The manager informed us how this had improved concerns they had around delayed calls due to insufficient travel time. The manager described how they monitored the information from the electronic care records and had been able to identify any patterns and act. The operations manager told us they were in the process of changing the electronic roster system to make further improvements.

A robust recruitment and selection process was in place and all staff had been subject to criminal record

checks before starting work. These checks were done by the Disclosure and Barring Service (DBS) and supported employers to make safer recruitment decisions and prevent unsuitable staff being employed.

Staff understood how to prevent and control infection and people confirmed that staff followed procedures, for example wearing gloves and aprons. The management team analysed accidents and incidents, learnt from this analysis and made improvements as a result. For instance, medication errors and falls were reported within key performance indicators. These were then reviewed and corrective action reports were completed to reduce the likelihood of future similar incidents.

Good

Is the service effective?

Our findings

One person described the staff as 'excellent' and said, "Bluebird staff are some of the best". Another person said they were "Very satisfied with the service and on the whole would give them full marks."

People's needs were met to enable them to continue living at home independently with support. One relative described how the support provided had enabled their loved one to stay at home within the community they had been part of for years, rather than go into residential care. People's care plans included their assessed needs and considered their choices and any needs around equality and diversity.

The provider ensured care staff had the right induction, training and on-going support to do their job. Staff recruitment files confirmed this and included evidence of shadowing visits and probation meetings. The manager told us that all induction training was face to face to ensure staff interaction, the sharing of experiences and practical group work. Staff completed the Care Certificate which is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sector. Once staff had completed their probationary period they started QCF training. QCF replaced NVQ's as a nationally recognised training qualification. The training manager sent staff monthly emails about available training and best practice in various areas, for example dementia and strokes.

Care staff received periodic supervision and appraisals. Staff files included observational supervision records and evidence of spot checks which recorded the care staffs' conduct and presentation. The provider had implemented a staff guide app for phones where staff could access easy to read information they might need. For example, what to do if someone had a fall. This ensured that staff always had access to guidance. We asked the manager if any care staff had struggled with using the new technology and were told that where staff were worried about using the electronic systems they were given additional support. The provider bought one care worker a phone to enable them to have access.

People were supported to eat and drink enough to maintain a balanced diet. Care plans included information about people's nutrition and hydration needs, for example the need to leave water in easy reach of the person before leaving the call. One person told us they got enough to eat and drink, they said "They cook lunch for me, I get enough, it's very good". The provider monitored that people received the support they needed with eating and drinking through their electronic care records system.

People were supported to access healthcare. People's care records included 'hospital passports' and the manager told us they had received good feedback about these from health professionals. Hospital passports provided hospital staff with important information about the person and their health when they were admitted to hospital. The provider worked with partner organisations to ensure people received the care they needed. In addition to this they offered their services voluntarily. For example, visiting people in hospital to share the dementia app they used.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible,

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA. People's care plans had a privacy statement and they were asked to consent to their care. We saw care plans had been signed. Where people had a Lasting Power of Attorney (LPA) in place, these documents were available in people's care records. A LPA is a legal document that lets the person appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf.

Good

Is the service caring?

Our findings

People and relatives told us the staff were caring. One person said staff were "Very friendly, courteous, kind and caring" and one relative said, "I haven't come across any staff that aren't caring". Another relative, when asked how staff showed they were caring said, "They talk to (the person), they don't rush". The service had all positive reviews on NHS choices, for example, one person had wrote 'My carer is a breath of fresh air. It is a good start to the day having them come in and be as bubbly as they are'.

The management team were committed to ensuring there was a culture which promoted treating people with kindness, respect and compassion. Care plans reflected this. The operations manager was passionate about their role and told us that the provider had started a new complimentary scheme to visit people when they were in hospital. They described how one person refused to get out of bed for the nurses but did so for the carer who supported the person's rehabilitation. The care manager informed us when a person had limited visitors they would take them out for a complimentary lunch every two months.

People and relatives were consulted in decisions about their care during assessment and through their care reviews. There was a consistent theme from the provider's quality reviews and from feedback received, that people were not always informed if a different carer was planned to visit. One person told us that "There is sometimes confusion about who is coming". One relative of a person who received live-in care told us they were concerned that their loved one was not informed about plans for a temporary carer while their usual carer had a holiday. However, they informed us that their concern had been addressed by the manager. The manager described how they tried to plan for consistent care staff, which can be difficult for live-in care when carers have a holiday. Surveys showed that the need to improve communication was identified and the manager actioned this by improving their meeting structure.

One person told us that staff protected their privacy and dignity and said they had, "No problems with this whatsoever". Staff told us how they respected people's privacy and dignity. For example, ensuring doors and curtains were closed and covering people up when providing personal care. People were encouraged to remain as independent as possible. For example, one care worker told us how one person they supported started to cook their meal before they arrived. Therefore, the care staff were promoting people to do things for themselves. Another care worker told us how they encouraged people to get themselves changed.

The manager told us that people were not accessing advocacy services, however where a person's capacity was in question they would speak to their GP to obtain an assessment and then refer them to the relevant service when needed. Advocacy services offer trained professionals to support, enable and empower people to speak up.

People's needs around equality, diversity and human rights were considered. A supervisor told us "Everyone is individual…we ask them to tell us about how they like things done or any other special details so we can add it to their care plan. We always remind staff to make sure they ask their customers, not assume they already know".

Good

Is the service responsive?

Our findings

We saw that people and their relatives had been involved with their care planning and review. One person said, "They do the best they can". A relative told us they were very involved and had Lasting Power of Attorney for their loved one's health and welfare. Relatives could securely access people's electronic care records where consent had been given. One commissioner fed back to us that "They have provided a great service, being attentive to the cared for needs and carers wishes as some of the packages we request can be quite specific".

People received personalised care which was responsive to their needs. Care plans were person centred and looked at what was important to the person and were tailored to their individual needs. For example, one person who did not speak English was supported by carers who could speak their first language. Staff were equipped to meet people's needs and had access to immediate electronic guidance to enable them to respond quickly. The manager told us they had introduced a new tool to support people with dementia in the form of an interactive app which provided 'person centred reminiscence built around the person's life'. Feedback they had received on this was all positive. As a result they have shared their work and visited people on dementia wards in the local hospitals and used the app.

The service considered the Accessible Information Standard (AIS) when they assessed people's individual communication needs. AIS was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. Providers of health and social care services are required to follow the standard. The operations manager told us how they produce their newsletter in different formats such as braille and on a DVD.

The operations manager told us they provided free outings for individuals outside of their usual calls, for example a trip out for lunch or to a garden centre. They also offered larger scale events three times a year free to all people. For example, they hired a bus to take people to Hastings the week after our inspection for fish and chips, ice cream and to play the penny machines.

People and relatives could raise any concerns or complaints they had. One person told us they had raised concerns in the past which 'were handled and put right'. We saw that the provider actively sought feedback from people and their relatives. Complaints were recorded, monitored and managed appropriately.

The manager told us they received an advanced care plan from commissioners when they took on a new care package for someone who was at the end of their life. The care supervisor told us they were sensitive to the fact they were supporting people in their own homes, that it was important they talked to the person or family to gather information and if anything changed they reviewed and updated their care plan. End of life care was included in the agenda for the provider's monthly managers meetings and was discussed to ensure people received the care they needed. All staff received end of life care training during their induction.

Good

Is the service well-led?

Our findings

The care manager was in the process of applying to be a 'registered manager'. '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.'

People told us they thought the service was well managed and said, "they came to see me at the start, asked me what I wanted, then arranged it". Relatives said their views were sought and that managers listened to their concerns and acted on them. Staff told us they felt supported by the managers and said, "They are always on the end of the phone" and "They always ask me if there is anything I need".

The provider had good oversight of the quality and safety of the service and risks and regulatory requirements were clearly understood and managed. Internal audits and surveys were completed, reviewed and action plans developed as a result. For example, the manager was aware they were required to inform CQC of certain changes and important events that happen in the service. The management team promoted a positive culture that was person-centred. The provider had a statement of purpose which detailed positive values around seeing each person as unique and giving them control by providing care in the way the person wanted it. Newsletters and emails sent to staff demonstrated this culture.

Regular management meetings and team meetings took place. During our inspection we found the managers were open and receptive to feedback. The provider showed how they valued their staff through complimentary events, recognition of milestones and awards. They conducted exit interviews with care assistants that had left their employment to understand why they left and to try to improve the service. Staff were supported in their roles. One member of staff said their manager was 'supportive and always on the end of the phone'. The director sent monthly emails to all care assistants asking for their feedback. Surveys were also completed by staff. These showed that staff felt they could approach the manager, that they would be listened to and they received enough support and supervision. The management team ensured staff were involved through monthly team meetings and free staff social events. All central and office staff had previously worked as a care assistant, which gave them a better understanding of the service which was provided, the needs of the care assistants and the challenges they might face during their work.

People and relatives were engaged in the service. The provider sought on-going involvement from people by completing periodic quality reviews after their first week, first month and after six months of care. These reviewed key questions, for example whether the care workers arrived on time and completed all tasks. They also looked at what the person valued about their care. For example, one person wrote "Being able to stay in my own home with my husband". Surveys were sent to people and their relatives and feedback from them, which informed people about actions taken, were included in newsletters.

The provider promoted continuous learning by paying attention to survey results and action plans from audits and making changes as a result. Duty of candour was shown in the way the managers fed back to

people actions they have taken as a result of their feedback. The provider was in the process of moving over to a new policy system. This enabled managers to have access to policies on their phones, and alerted them to any changes or updates they needed to cascade to their care staff team.

The provider has maintained close links with other agencies and actively supported their local community. For example, they had a community grant scheme which supported local charities and they had held regular fundraising events, for example coffee mornings to support cancer charities.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed a copy of their inspection report and ratings in the reception area and it was on the providers website.