Blue Tree Care Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Blue Tree Care Limited is a domiciliary care agency which provides care and support to people living in their own homes and flats in the community. The care agency offers a variety of services, including assistance with personal care, support with medicines and domestic tasks. Not everyone using Blue Tree Care Limited receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided.

We carried out this inspection on 26 February 2018. The inspection was announced to ensure that the registered manager or other responsible person was available to assist with our inspection. Blue Tree Care is a relatively new service and this was its first CQC inspection. At the time of our inspection, the service was providing support to eight people, the majority of whom lived in the Glodwick, Werneth, Clarkesfield and Coppice areas of Oldham. The service was run from an office in the home of the registered manager.

The service had a registered manager, who had registered with the CQC in February 2017. 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.

At this inspection we found breaches of three of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to the safe management of medicines, lack of detail in care plans and lack of an auditing system to monitor the quality of the service. You can see what action we have told the provider to take at the back of the full version of the report.

People we spoke with were complimentary about the care their relatives received from Blue Tree Care. They told us their relatives were safe, and that the staff were caring and treated their relatives with respect.

Recruitment checks had been carried out to ensure staff were suitable to work with vulnerable people. Staff had been trained to carry out their roles and were regularly supervised. The registered manager carried out weekly 'spot checks' where they observed care being provided. This ensured the standard of care was monitored and people had an opportunity to comment about the support that was given to their relatives.

There were sufficient staff to provide care to the people being supported by the service. Work rotas were arranged so that people were generally supported by a regular carer who was familiar with their needs. Staff used the appropriate equipment, such as disposable aprons and gloves when carrying out personal care tasks.

We found a lack of systems in place for the safe administration of medicines. There were no specific care

plans to guide staff on the way to support people with their medicines. Documentation used to record when medicines had been given was not in line with current guidelines on best practice. Care plans did not contain sufficient detail and some were not accurate.

There were systems in place to record accidents, incidents and complaints. People told us they were happy with the way the service communicated with them. The service had engaged with the local community through its contact with local mosques.

There was a lack of formal systems for monitoring the quality of the service, although the registered manager regularly sought verbal feedback from people who used the service and their families about the standard of care they received.

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 consistently safe.

There was not adequate documentation in place to ensure medicines were administered safely.

Arrangements were in place to safeguard people from harm and abuse.

There were sufficient staff to meet the needs of the people using the service. Recruitment checks had been carried out. This helped to ensure staff were safe to work with vulnerable adults.

Is the service effective?

Good

The service was effective.

Staff had received an induction to the service and training to prepare them for their role.

Staff received regular supervision.

Is the service caring?

Good

The service was caring.

People were complimentary about the staff and about the care that they provided.

People's dignity and privacy were respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Some care plans did not contain sufficient detail or accurately reflect the care that was provided.

People were happy with the way the service communicated with them.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was a lack of a formal system to regularly monitor the quality of the service.

The service engaged with the local community.

The registered manager was keen to improve and develop the service.

Blue Tree Care Limited

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.

The inspection took place on 26 February 2018 and was carried out by an adult social care inspector. We gave the provider five days' notice of our inspection. This was because the location provides a domiciliary care service and we needed to be sure that someone would be in the office to assist us with our inspection.

Before the inspection we reviewed information we held about the service, including the provider information return (PIR). A PIR is a document that asks the provider to give us some key information about the service, what the service does well and any improvements they are planning to make.

We sought feedback from Oldham Clinical Commissioning Group and Oldham Healthwatch and asked them if they had any current concerns about the care provided, which they did not. Healthwatch is the national independent champion for consumers and users of health and social care in England.

During our visit we spoke with the registered manager and the deputy manager. We were unable to speak with care assistants on the day of our inspection, as they did not attend the office. However, we spoke with three care assistants on the telephone after our inspection site visit. On the day of our inspection we visited two people in their own homes and spoke with their relatives. We also spoke on the telephone with three relatives of people using the service to gather their opinion about the care provided. We were unable to speak to people who used the service themselves. This was because of communication difficulties, such as English not being their first language and in some cases because of health conditions.

As part of the inspection we reviewed three people's care records which included their care plans and risk assessments. We also reviewed other information about the service, including training and supervision records and three staff recruitment files.

Requires Improvement

Is the service safe?

Our findings

Relatives of people who used the service told us they felt their loved ones were safe with the care provided by Blue Tree Care Limited. Comments included, "Without a doubt she's safe"; and "I feel he's safe in their hands.'' The service had safeguarding and whistle-blowing policies to guide staff on best practice and staff had completed training in safeguarding as part of their induction. Those we spoke with understood what signs might indicate a vulnerable person was at risk and what they should do to protect them.

The care agency was run from an office which was in the basement of the registered manager's home. This provided suitable premises, where people's personal information was securely stored.

We reviewed three staff files to check the recruitment process. The records contained photographic identification, Disclosure and Barring Service (DBS) checks and two references, which had been verified to ensure they were genuine. A DBS check helps a service to make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable adults and children. None of the files contained application forms. The registered manager told us that some of the people who had been employed lacked the confidence to complete them correctly. To address this issue the service had provided training in the writing of curriculum vitae and completion of application forms and all staff who had been employed had been requested to complete an application form in retrospect.

Staff had undertaken training in infection prevention and control as part of their mandatory training. All staff in a care and support role wore a uniform. Personal protective equipment (PPE), such as disposable gloves and aprons was provided by the service and kept at the home of each person receiving care. A stock of PPE was kept at the service office. All staff carried anti-bacterial hand gel for de-contaminating their hands. We asked people if staff used gloves and aprons when carrying out personal care tasks and they confirmed that they did. This helped protect people who used the service from the risk of cross infection.

Some of the people using the service were Muslim. It is normal etiquette for visitors to remove their shoes when entering a Muslim person's house. However, as it would not be practical or safe for staff to remove their shoes while assisting with care tasks, the service provided disposable over shoes. This meant the service protected staff, while respecting people's traditions and religious customs.

Some people using the service received support with their medicines. As part of our inspection we checked to see if this was safely and correctly managed. From checking the care files we found that documentation in relation to medicines administration was not sufficient to ensure medicines were given safely. It was not in line with current guidance provided by the National Institute for Health and Care Excellence (NICE). A medicines administration record (MAR) which lists each individual medicine and enables staff to accurately record details about medicines administration
was not used, although staff did record the number of tablets given. Feedback we received from the local authority showed that the concern around lack of MARs had recently been highlighted by themselves during a person's care review. The service had agreed to request printed MARs from their supplying pharmacy in future. Although this had not been implemented at the time of our inspection, we were assured printed

MARs would be introduced for all people receiving support with medicines. This showed the service took action to learn from concerns.

People did not have a medicines care plan to guide staff on the exact support that was required. For example, the daily records for one person showed that staff had administered eye drops. We saw that staff had recorded ''I put four eye drops in'' and ''we put in eye drops''. The registered manager told us that staff did not administer eye drops, but guided the person's arm to help them get the drops in the correct place. However, there was no care plan to say in which way staff should support this person with their eye drops. Records showed that staff had applied a cream to this person's back. There was no care plan, or body map to show what cream should be used and where and when it should be applied.

Failure to have systems in place to manage the administration of medicines safely is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

The service had a procedure in place for recording and investigating any accidents or incidents. However, there had not been any since the service became registered with the CQC in February 2017. The registered manager told us that appropriate authorities, including the CQC, would be notified immediately of such events if they occurred.

Blue Tree Care is a relatively new organisation. Although it had registered with the CQC in February 2017, the majority of its care packages had started during recent months. At the time of our inspection there were eight people using the service. Fourteen care assistants were employed by the service, although most worked part-time. Through talking to relatives we concluded that there were sufficient staff to provide safe and effective care. People told us that there was continuity of care, as their family member received support from the same, regular care staff. This was important to them. One person told us, "(Name) has taken to each of them.'' People commented that staff generally arrived on time and if they were going to be late they were informed.

The registered manager told us that the majority of the care team and people receiving support from Blue Tree Care, lived locally to the office. This enabled care assistants to walk to their visits. Some staff had the use of a car and were able to undertake care visits further afield. The registered manager told us that all new staff were introduced to people using the service at the start of their employment. This gave people the opportunity to meet new staff.

As part of the initial assessment process, environmental risks, such as condition of lighting, and appropriate space for carrying out care tasks in people's homes had been completed. This showed the service considered risks posed to staff during the course of their work and the need to take action, when appropriate, to mitigate identified risks. In addition to environmental risk assessments, personal risk assessments for people receiving care had been carried out. These included, for example, falls risk assessments and moving and handling risk assessments. We saw that where one person's risk assessment had identified a risk around moving and handling, the action taken to mitigate the risk had been to use a particular piece of equipment to lessen the potential risk to staff.

Good

Is the service effective?

Our findings

We looked at the training and supervision of staff. Staff working for Blue Tree Care had received induction training in a range of topics, including infection control, dementia care, safeguarding vulnerable adults, medication awareness and record keeping. The induction programme consisted of face-to-face training carried out in the service office, followed by a period of supervised care. At the start of their employment care assistants were given a staff handbook which contained some useful policies and other information relating to their role, such as information about sickness and absence and the disciplinary procedure. Recruitment files we checked showed that people had completed their induction training. The majority of staff employed by Blue Tree Care had some experience of providing care and support to people, although for some staff this had been through caring for family members or children rather than in a paid role. Staff told us that although they had some 'caring' skills they felt it was important to be correctly trained in a more formal way.

Care staff had received some training in moving and handling people, for example, by using a slide sheet if the person was unable to turn or roll while they were in bed. People we spoke with were happy with the way care assistants helped their relatives with their mobility, such as guiding them to sit in a chair. No staff were trained to use a hoist. Where people required moving in this way it was carried out by a family member. Care assistants we spoke with told us that they were shown how to carry out basic care tasks, such as assisting people to wash and dress, by the deputy manager and registered manager. This training was given during a period of shadowing, where the care assistant worked alongside someone in order to gain experience. Through talking with staff we found that they had received sufficient training to equip them in their roles. The registered manager told us that future training was scheduled to be completed annually.

Staff were supported in their roles through monthly face-to-face supervision. Supervision is important as it provides staff with an opportunity to discuss their progress, identify any training needs and talk about any concerns they might have about the people they are supporting. The registered manager told us that she was keen to ensure that high standards of care were achieved and maintained and that this was particularly important as the company was new. At present she visited all people using the service on a weekly basis to ensure they were happy with all aspects of their care package. In addition she carried out 'spot checks'. This involved making an unannounced visit and observing the care carried out by care assistants to check that care tasks and documentation were completed correctly. Spot checks help to ensure staff are carrying out care to the required standard. One person we spoke with commented, "They do spot checks, which is brilliant.''

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the service was working within the principles of the MCA. Staff had received training in

the MCA in order to help them gain an understanding around issues of capacity, choice and consent. People we spoke with told us staff sought consent before carrying out care tasks.

If it was part of their agreed care package, people could receive support with meals. The registered manager told us this was only basic support, such as preparation of a sandwich or toast, heating up meals in a microwave and making drinks. Staff had undertaking training in food hygiene as part of their induction training.

People's records included contact details of any health professionals who were involved in their care, including community nurses and GP's. The registered manager told us that they had recently worked closely with the community palliative care to support a person at the end of their life. This showed the service worked closely with other health professionals in order to promote people's well-being and comfort.

The registered manager told us how they had responded to the particular cultural needs of some people using the service. For example, some people required assistance with 'Wudhu' (ablution). Wudhu is the ritual washing performed by Muslims before prayer. Care assistants, who were knowledgeable about this procedure, were able to assist people with this important aspect of their personal care. The service had close contact with three local mosques and an Imam had visited the service and explained the 'ghusl' procedure, which is the Islamic rite of washing and shrouding performed by family or other Muslims within a local community when a person has died. This gave care assistants the knowledge to assist families with this ritual, if required, and showed that the service worked closely with other organisations to deliver effective care.

Good

Is the service caring?

Our findings

People we spoke with were complimentary about the service their relatives received from Blue Tree Care Limited. One person told us, "They are absolutely lovely with (name).'' We read a 'thank you' card the service had received. It said, "We wanted to place on record our very great thanks to you all for the wonderful care, attention and love that you have given to (name) unconditionally. You all fully understood and appreciated what (name) needed and attended to their every need in such a professional and compassionate way. We can't thank you enough.''

We asked people if staff treated their relatives with dignity and respect and everyone responded positively. One person talked to us about how staff provided personal care for their relative while they were in bed and that this involved moving the person using a 'slide sheet'. This is a piece of equipment used to help move someone without causing injury to the person or to those using it. They told us, "They handle her with care and respect.'' Staff we spoke with could describe ways they would ensure that a person's dignity was maintained while carrying out personal care. Although we could not find written evidence within the care files that staff actively promoted people's independence we were told that staff helped people to do as much they could for themselves when they were able. One person told us about their relative, who was very proud and had been reluctant to accept that they needed support. They told us that staff had respected this person wishes and had helped them maintain their independence. They were very happy with the care and support they received.

We could not find written evidence to show people had been involved in decisions about their care. This has been discussed in the 'Responsive' section of this report. However, through talking with the registered manager and relatives we found that the service was keen to ensure people were actively involved with planning and reviewing their care and the registered manager told us she visited people on a weekly basis to discuss any changes that were needed to their care package.

The cultural and religious backgrounds of people were always respected. Over half of the people who currently used the service were from Pakistan and Bangladesh and all the care team were able to speak several languages, including English, Urdu, Punjabi and Bengali. The registered manager told us that as part of the assessment process people were asked what language they would like staff to use, and where possible a care assistant who was able to communicate with them in that language was allocated to support them. Where staff had indicated that they felt uncomfortable caring for a person of the opposite gender, because of cultural or religious reasons, the service as far as possible had accommodated their request. This showed that the service respected the cultural and religious needs of both staff and people who used the service.

Although people who used the service had set times for their visits, we were told these could be rearranged to accommodate unexpected events, such as hospital appointments and for religious festivals such as Eid. People we spoke with told us that care assistants stayed for the full amount of time for each visit and that work was unrushed. The registered manager told that where possible they tried to arrange the rota so that care assistants supported people who lived near to where they lived. This helped to limit travel time and

reduce the anxiety of travelling between visits in a set time.

Requires Improvement

Is the service responsive?

Our findings

People told us they were happy with the care provided by Blue Tree Care. One person said, "I've no negatives at present. So far they have been very good.''

We looked at how the service assessed and planned the care it provided. Following an initial referral to the service from a commissioning authority, a needs assessment was carried out in conjunction with the person and/or their family, using the local authority care plan as a guide. The assessment gathered a range of information including details about mobility, nutrition, hygiene, personal care, communication, and the home environment and this was used to create care plans which described what care and support the person required.

We reviewed three care files held in the service office. These contained comprehensive information about each person, including health details, risk assessments, the council care plan and an overview of the care plan. The overview of the care plan was divided into sections which contained information about 'daily care, morning, afternoon, evening and night care, checks to be made upon leaving the property and any special notes.' However, we found that these did not give sufficient information or detail to guide staff on the support that people required. For example, in the 'morning care' section of one plan it stated 'bed bath, showering, breakfast, eye drops, change clothes, oral care, change bedding.' There was no further information to say how the person should be supported with these tasks, such as information about their own ability, or the need for staff to promote choice and encourage independence. We also found that information was not always accurate. One plan stated 'apply/administer eye drops'. However, we were told that staff did not administer eye drops, but only 'supported' the person's arm to guide them while they put their own drops in. This has been discussed in more detail in the safe section of this report in relation to lack of medicines care plans.

We visited one person in their home and checked their care file. Although it contained records written by care assistants which described the care they had provided, it did not contain any care plans to guide staff on how they should support this person. Daily care records stored in the service office, which we viewed, did not always have the person's name recorded on them. Some we saw did not have the times of visits recorded. We also found there was no written evidence in care plans to show that they had been discussed with the person using the service or a person acting on their behalf.

Failure to provide accurate, person-centred and detailed information in care plans is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

People we spoke with were happy with the way the service communicated with them. One person told us that staff always informed them if their relative's toiletries were running low. They said "it's being informed about the little things that helps.'' Another person told us they had a good relationship with the registered manager and that they were "on hand all the time.'' They told us they felt comfortable about calling or texting the registered manager if they had any concerns. People told us that staff were observant and kept a close eye on their relative's health. One person told us that they were immediately contacted by phone or

text if a care assistant noticed their relative was unwell. The four relatives we spoke with all said they would feel able to make a complaint or raise concerns and that they would be dealt with.

Requires Improvement

Is the service well-led?

Our findings

Relatives we spoke with were complimentary about the management of Blue Tree Care and about the quality of the service it provided. One relative said, "This company are addressing all her needs.''
At the time of our inspection the service had a registered manager who had registered with the Care Quality Commission (CQC) in February 2017. The registered manager was supported in her managerial role by a deputy manager. Although the service had started in early 2017, the majority of people using the service had only been receiving care from them for short period of time.

During our inspection we spoke with the registered manager about how the service was founded, their motivation for starting the company and how they had developed it to its current position. They told us that at present they had no plans to expand. Their aim was to keep the company small so that they could ensure the care they provided was of a high standard. From our discussions during the course of the inspection we saw that the registered manager was committed to developing the service and was keen to implement any improvements needed.

We found that the registered manager had not yet developed a formal system for regularly auditing different aspects of the service. Auditing helps a service identify areas for improvement and can be a useful tool for improving quality. During our inspection we identified concerns around the safe management of medicines and insufficient detail in care plans. We have discussed these concerns in the relevant sections of this report.

Lack of a formal auditing system to monitor the quality of the service is a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, we found that the registered manager regularly asked people who used the service for their opinion about the care and support they received. This showed they were aware of the importance of gathering feedback and using this to drive improvement.

The registered manager talked to us about the importance of valuing the work undertaken by the care team. Some of the staff worked part time, often only working a few hours a week. The registered manager told us she tried to arrange the staff rotas in such a way that accommodated people's part time hours and where possible enabled them to work close to home. Staff we spoke with appreciated the way the registered manager managed their work load and their flexible approach. In order to show staff that they were appreciated she had introduced an 'employer of the month' award with a £30 voucher offered to winners.

The registered manager had shown, through her liaison with local mosques that the service was keen to engage with the local community and support the people who lived there.

There was a plan to introduce regular staff meetings, although this had not yet been implemented. Staff meetings are an important method for communicating information, gaining staff opinions and promoting team work. The registered manager demonstrated an understanding of their responsibility to notify the CQC about important events that affect people using the service and to record and monitor accidents and

incidents to ensure lessons were learned.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans did not always provide detailed, accurate and person-centred information to guide staff in supporting people.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The management of medicines was not always carried out safely.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not have formal systems in place to monitor the quality of the service.