Blossom Care For You

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Inspection report

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Date of inspection visit:
21 December 2017

Date of publication:
16 May 2018

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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 21 December 2017. It was unannounced.

Blossom Care for You is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older people who may be living with dementia and younger adults who may have mental health needs. Not everyone using Blossom Care for You receives regulated activity. CQC only inspects the service being received by people provided with "personal care", that is help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

There was no registered manager in post at the time of our inspection. A registered manager is a person who has registered with the CQC 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.

We found the provider did not keep accurate and up to date care records with respect to people's medicines. The provider had not kept other legally required records up to date. This meant the provider was not meeting the fundamental standards required of all social care providers and was in breach of two regulations. You can see what action we told the provider to take at the end of the full version of this report.

The overall rating for Blossom Care for You was requires improvement. This was the first time the service has been rated requires improvement.

The provider had arrangements in place to protect people from risks to their safety and welfare, including the risks of avoidable harm and abuse. Staffing levels were sufficient to support people safely. Recruitment processes were in place to make the provider only employed workers who were suitable to work in people's homes. There were arrangements in place to protect people from the risk of infection and to learn lessons and make improvements when things went wrong.

People received care and support based on thorough, individual assessments and care planning. Staff received appropriate training to maintain and develop their skills and knowledge to support people according to their needs. Staff were aware of the need to seek people's consent to their care. Where appropriate people were supported to eat and drink and to have access to other care services.

There were caring relationships between care workers and the people they supported. People were encouraged to take part in decisions about their care and support and their views were listened to. Staff respected people's independence, privacy, and dignity.

People received care and support that took into account their abilities, needs and preferences. People were able to take part in leisure activities which reflected their interests. People were aware of the provider's complaints procedure, but there had been few formal complaints.

Staff were motivated to deliver a high standard of care and support that was focused on people as individuals. There were systems in place to manage the service, and monitor and assess the quality of service, although these had not identified all the concerns we found. Arrangements were in place to engage with people and their families, and to improve the service while sustaining the level of service delivered.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Records concerning the safe management of medicines were not always accurate and up to date. People were protected against risks to their health and wellbeing, including the risks of avoidable harm and abuse. There were sufficient numbers of suitable staff to support people safely. There were appropriate processes to maintain standards of cleanliness and hygiene to prevent the risk of infection.	**Requires Improvement**
Is the service effective? The service was effective. People's assessments and care planning were thorough and led to good outcomes. Staff had the required skills, knowledge and experience, including around how people gave consent. Where required the service worked with other agencies and professionals to deliver care which took into account people's healthcare and nutritional needs.	**Good**
Is the service caring? The service was caring. People were supported in a caring, compassionate way and their independence, privacy and individual dignity were respected. People were supported to make their views and opinions about their care known.	**Good**
Is the service responsive? The service was responsive.	**Good**

People's care and support took into account their needs and preferences.

There was a complaints process, and people knew how to complain.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had not met all their regulatory requirements, including the requirement to have a registered manager with day to day responsibility for the service.

Systems were in place to engage with people and to monitor and assess the quality of service.

Blossom Care For You

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 was 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 21 December 2017. We visited the office location on this date to see the manager and office staff, and to review care records, policies and procedures. In the days following the office visit we contacted staff and people who used the service by telephone.

This was the first inspection of Blossom Care for You. The inspection was unannounced. The inspection team comprised two inspectors.

Before the inspection we reviewed information we had about the service, including previous inspection reports and notifications the provider sent to us. A notification is information about important events which the provider is required to tell us about by law.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make

We spoke with five people who used the service or a close family member who was involved in their care and support. We also spoke with five members of care staff, the manager of the service and two directors.

We looked at the care plans and associated records of four people. We reviewed other records, including the provider's policies and procedures, a staff handbook, training and recruitment records, medicine administration records, staff rotas and timesheets, and recruitment records for three staff members. We looked at records of complaints, safeguarding concerns, accidents and incidents.

Requires Improvement

Is the service safe?

Our findings

People were satisfied they received their medicines as prescribed and at the right time. The manager told us all the people receiving personal care would be able to raise a concern if they did not receive their medicines properly.

However, we found medicines records did not fully protect people from the risks associated with medicines. One person's records were not consistent with respect to the list of their prescribed medicines. There were differences between their medicines risk assessment and their medicines administration records (MAR). The paper version of their records was different from the version on the provider's computer. There was a risk the person would not receive their medicines as prescribed.

The same person's care plan for pain relieving medicines prescribed to be given "as required" did not contain enough detail to make sure these medicines were administered safely. Their MAR stated that one medicine should not be given "with" the other, but this was not reflected in their risk assessment. There were no instructions for staff on how to decide which pain relieving medicine was appropriate in which circumstances.

A second person's care plan stated they preferred to administer their own medicines and were "independent" in this respect. However records showed they should use an eye gel three or four times a day. There had been none available for a period of 25 days, and no records to show staff had raised this as a concern.

A third person's medicines risk assessment did not include eye drops or prescribed creams which were included in their other medicines records. Guidance for staff did not take into account any risks associated with their eye drops and creams. There was a risk of inappropriate care or support.

Failure to keep accurate, complete and up to date records with respect to people's care was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took steps to protect people from the risk of avoidable harm and abuse. Staff were aware of the types of abuse, the signs and indications of abuse, and how to report them if they had any concerns. None of the staff we spoke with had seen anything which caused them concern, but they were confident any concerns would be handled promptly and effectively by the manager.

The manager was aware of processes to follow if there was a suspicion or allegation of abuse. Induction and refresher training was in place to maintain staff knowledge about safeguarding. Suitable procedures and policies were in place for staff to refer to, including the local authority's multi-agency protocol for safeguarding.

The provider had identified and assessed risks to people's safety and wellbeing. These included risks associated with people's medical conditions, care needs and their home environment. Where appropriate they had discussed risks with other agencies, such as the local authority safeguarding team.

The manager told us they had identified some risk assessments where the records were not up to date and did not contain all the necessary information. They had made sure staff were aware of the risks and actions to manage them and had started to bring the records up to date. We found risk assessment records which were not individual to the person and did not contain clear instructions for staff to follow when supporting the person.

There were sufficient numbers of suitable staff to support people and keep them safe. People were satisfied their calls took place at the right time and that staff stayed for the right length of time. The manager told us there were sufficient staff to cover the existing rotas. They were recruiting more staff for contingency and to allow the business to expand.

The provider carried out the necessary checks before staff started work. Staff files contained proof of identity, a criminal record check, employment history, and evidence of good conduct in previous employment. The manager told us they used interviews to identify and screen candidates who were not suitable to work in a care setting. They did not use agency staff but had a stable work force including a pool of temporary employees they could use.

Records showed that checks had been made with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable staff from working with people.

People told us and staff confirmed that appropriate procedures were in place to manage the risk of infection. Staff took the necessary precautions with respect to hand washing and use of personal protective equipment. Gloves and aprons were available and used. Staff calling on one person also used shoe covers at the request of their family.

There was a computer based system for recording and logging accidents, incidents and near misses. There was a process in place to analyse and review these, but there had not yet been any patterns or trends identified from which the service could learn.

There were systems in place to share lessons and other information about safe practice with staff. These included staff meetings and supervisions, staff memos and mobile phone text messages for urgent information. There had been a recent staff meeting where staff were brought up to date around issues of safe practice.

Good

Is the service effective?

Our findings

People's assessments and care plans were based on forms the provider had developed. They took into account input from people and from their families where appropriate. They reflected people's preferred routines and preferences, and were individual to the person. The manager told us they intended to review all care plans to make sure they were fit for purpose and took into account current guidance and standards.

Staff recorded care delivered in care logs which were used to verify that care was in line with people's assessments and plans. Staff were conscientious about reporting changes in people which might indicate a change in their needs, such as if the person was sleeping more than normal or if their general health appeared to be declining. This input was taken into account when reviewing people's care plans.

People we spoke with were happy that staff who called on them had the skills and knowledge they needed to support them effectively. Staff told us their induction and training prepared them to do a good job, and they felt supported by the manager. Induction training was based on the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Training records showed all training considered mandatory by the provider was up to date with a schedule for when refresher training would be due. However, records of supervisions, one to one meetings between staff and the manager, were not in place. The manager was aware there was a backlog of supervisions and had made contact with each member of staff at least once since starting in the role. Although formal supervisions had not taken place according to the provider's own procedures, there had been informal contact between the manager and staff, and staff were happy with this arrangement. They told us they could contact the manager at any time if they had any concerns.

Staff were trained in food hygiene and how to support people to eat and drink if required. However, at the time of our inspection, support in this area was limited to preparing food bought by the person or their families. If requested by a person's GP or social services, staff made records of people's food and fluid intake during their calls.

Among the people supported by the provider at the time of our inspection none had care plans which required regular working together with other agencies or healthcare providers. Staff had guidance on how to cooperate with paramedics in an emergency, what information they would need and which records needed to accompany the person if they were admitted to hospital.

In most cases, people's families were responsible for arranging doctors' appointments and other access to healthcare services. The manager told us of one example where a person's GP had appreciated the information in the person's records which showed how the person had been feeling in recent days. Feedback from families indicated they felt the service their loved one received had a positive effect on their general wellbeing. People looked forward to their care calls. One person was at risk of self-neglect, but this risk had reduced since they had been receiving care from the provider.

Staff were aware of the need to seek consent for any care or support. Records showed people's consent to their care plans was documented. If people declined planned care, their wishes were respected. Staff reported this to the office. If it happened regularly then the provider sought medical or other advice.

The Mental Capacity Act 2005 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.

The manager was aware of the legal requirements concerning mental capacity, and that people should be assumed to have capacity unless a proper assessment showed otherwise. They told us none of the people supported at the time of our inspection had been assessed as lacking capacity, and this was reflected in their care plans.

Good

Is the service caring?

Our findings

People we spoke with told us the staff were very kind and caring. All of the people we spoke with confirmed they felt well cared for and that the staff spent adequate time caring for them as well as spending time speaking with them and giving emotional support when needed. People gave very good feedback as to the quality of care from the service.

The manager told us there was a focus on caring characteristics during interview and induction. This had resulted in a staff team they found to be caring and compassionate. They said, "The team are great, they really care and help each other out to ensure the people they work with get the best care possible and no one has missed visits if there is staff sickness. They go the extra mile." Staff told us they had "more than enough time with people", and "extra time to spend with them to be able to talk".

People had consistency of staff so they could build a rapport and trust with them. Where there was a change in staff, there was a period of time when the new care worker went out with the current care worker to make the transition less disruptive. People received calls from their care worker or the office to let them know if there was going to be a delay in their call.

Staff spoke about people in way that showed they cared. One member of staff told us, "If I feel there is something upsetting or distressing someone I will ask what is wrong, whether I can help or call someone for them." People we spoke with said "I receive a very good quality of care", "We are really happy with the care provided, they have been really helpful and supportive", and "They actually really care and they make a world of difference to my life".

People told us they were involved in the planning of their care and had their wishes and independence respected in the process. There was evidence of this involvement in people's care records. Where staff noticed people's preferences had changed with the passing of tim, this was fed back for inclusion in care plan reviews.

People told us they felt they were treated with dignity and respect. One person's partner told us how staff asked other people to leave while they supported the person with personal care. Another person said, "They keep me covered and warm." People felt they had as much independence as possible. One person said, "Yes I have my independence." Another person's relation said, "[Name] cannot have any independence with her condition but I feel if she could she would be given that choice."

Staff were aware of the importance of maintaining people's dignity and described how they achieved this. One said, "We ensure the curtains are closed and any other people in the house are out of the room when we are washing a person. We keep them covered as much as possible." Staff told us how they supported people to be as independent as possible. One said, "We ask people what they would like us to do so they have their independence when we are in their home." Another said, "People's level of independence depends on their care needs but this is assessed and people are asked how much independence they would like or what they wish to try and do independently."

Good

Is the service responsive?

Our findings

People told us they received care and support that met their needs and reflected their preferences. One person said, "All my needs are met." Another person said, "I was feeling unwell so my carer called 111, my daughter and the office to let them know. She then stayed with me until my daughter came."

Staff described how they delivered care that met people's changing needs or reflected changing circumstances. One staff member said, "I would call other professionals, a family member or medical services if I felt it was needed, I would also report to the office so if I was running late they would get my next visit covered by someone else." The manager told us of an incident that day where a staff member had needed to call an ambulance after calling on a person to find they had fallen. They had called the manager and family after the phone call to request an ambulance.

People were involved in the planning of their care. Everyone we spoke with confirmed this. Where appropriate people's family were also involved. One person told us they had their son read their care as they had a visual impairment.

People's care plans were reviewed every six months, or if their needs changed. The manager said, "The carers are aware of the people's needs and if they feel their care plan needs updating before the six monthly review then they call me and I will review it." The manager had a good relationship with people's families. She said, "They know they can call me with any questions regarding their loved one's care."

People's care plans had information about what was important to the person, as well as their care needs, wishes regarding independence and risks. The manager was aware there was some variance in the quality of information in people's care plans and had plans to review them all to bring them to the same standard. She was confident this was not affecting the care people received because she had regular positive feedback from people, and the people supported by the service at the time of our inspection were able to communicate their needs. Where people needed specific support to communicate, this was limited to making sure they were wearing hearing aids and spectacles.

People and their families were aware of how to complain if they needed to. The manager told us they went through the complaints procedure when they met people and their families who were new to the service. She said, "I make sure they know they can call me or the office at any time if they are not happy with their care in any way." People confirmed this was the case. They told us they found the service to be responsive in the way they received complaints. One person's family member told us how they raised a concern about how their loved one was supported. The provider had listened and made rota changes to resolve the issue to their satisfaction.

The provider had a logging system for formal complaints. There was one complaint on file. It had been dealt with efficiently, in line with the provider's procedure, and to the complainant's satisfaction.

None of the people using the service at the time of our inspection was receiving end of life care, so we did not inspect this key line of enquiry.

Requires Improvement

Is the service well-led?

Our findings

The provider did not have a registered manager in post at the time our inspection. The previous registered manager had notified us that they had resigned as registered manager one month before our inspection. The provider had appointed a new manager who told us they had received a thorough handover from the outgoing registered manager. They intended to apply to be the registered manager. However, following the inspection we did not receive an application from the new manager.

The manager had found the service well organised, helpful and flexible. People using the service experienced positive outcomes. Staff were motivated and receptive to change. There had been positive support from the directors of the provider company who were experienced in social care.

However the manager had identified that they needed to review all care plans. We also found areas where people's care plans could be improved. In two examples records were inconsistent about whether the person was "subject to the Mental Capacity Act". In both cases the person's assessment stated they were "subject" to the Act, but there were no records of a mental capacity assessment as required by the Act. It was not clear whether a person "subject" to the Act was identified as needing further assessment or was presumed to have capacity.

We also found the provider's statement of purpose had not been updated since the provider was first registered in September 2016 and contained out of date information. The statement of purpose is a document which describes the aims and objectives of the service, and information about the provider and any registered manager. The information about the registered manager had not been updated when the original registered manager left the service in December 2016. The registered manager's name, business address, telephone number and email address are compulsory content in the statement of purpose.

Failure to keep the statement of purpose current was a breach of Regulation 12 of the Care Quality Commission (Registration) Regulations 2009.

There were systems in place to manage the service effectively. The manager was supported by two team leaders and a business manager, with a total of 15 staff supporting 38 people. The business manager was responsible for staff rostering. The responsibility for care reviews was shared between the manager and team leaders. The directors of the provider company were available to support the manager if required.

Staff had clear job descriptions and policies and procedures to follow. Staff told us they felt motivated and supported to deliver a high quality of care, although there had been few formal supervisions and appraisals. The manager carried out spot visits with staff to assess the quality of care, and supported people who used the service to complete quality assurance questionnaires. Records showed people were also supported to take part in care reviews either in person or over the phone.

The manager told us arrangements for more formal engagement with people, their families and staff were not yet in place.

The directors of the provider company told us that sustaining a high quality of service was important to them. They had ambitions to expand the service, but quality would not be compromised for quantity. They had started to recruit additional care staff in preparation for expansion, and had plans to increase the office staff with the addition of a care coordinator when required.

The provider worked with other agencies where the care and support commissioned for the person indicated this would improve their quality of life. There was cooperation with local social services, voluntary organisations and day services. When the provider had supported a person with a visual impairment, they had worked with the Royal National Institute for the Blind to develop a care plan that best met the person's needs.

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 12 Registration Regulations 2009 (Schedule 3) Statement of purpose The registered person did not keep under review and, where appropriate, revise their statement of purpose. Regulation 12 (2)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not maintain an accurate, complete and contemporaneous record in respect of each service user. Regulation 17 (2) (c)