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:
17 March 2017

Date of publication:
02 May 2017

Ratings

Overall rating for this service	Good
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

Bluebird Care (Tonbridge & Tunbridge Wells) provides care and support to adults who want to retain their independence in their own home. It also offers a "live in" service. It provides a service to mainly older people and some younger adults. At the time of our inspection, the service provided support to 132 people with a 110 receiving personal care.

We carried out an unannounced comprehensive inspection of the service on 15 June 2016. The service was in breach of one regulation relating to safe care and treatment. We found that medicines were not managed in a safe manner. Medicine records were not always accurately and fully completed.

Following our last inspection the service had provided us with an action plan telling us how they were going to ensure that the concerns raised were addressed. This report only covers our findings in relation to those legal requirements that were not met by the provider at our previous inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bluebird Care (Tonbridge & Tunbridge Wells) on our website at www.cqc.org.uk.

We undertook a focused inspection on 17 March 2017 to check that the service now met the legal requirement.

There was a registered manager in post as required. 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.

We found the registered manager and provider had taken sufficient action to address the concerns raised at the previous inspection and met the legal requirements in relation to medicines management. We saw the provider had reviewed the medicines management process at the service. Staff had received refresher courses in medicines management. The provider had introduced an electronic medicine management system which had ensured people received their medicines as required. However, the system was not fully implemented in managing all people's medicines and embedded. We will review the impact of the change to people using the service at our next comprehensive inspection.

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

We found that the provider and registered manager had implemented changes to improve the management of medicines and to ensure that people received their medicines when needed.

Staff had received training and refresher courses in managing people's medicines and their competency assessed. Audits and checks identified medicine shortfalls and the registered management put plans in place to minimise the risk of errors.

The registered manager and provider were now meeting legal requirements with regards to management of medicines.

While improvements had been made, we have not revised the rating for this key question because to do so requires a record of consistent good practice over time.

We will review our rating for 'safe' at the next comprehensive inspection.

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 undertook a focused inspection of Bluebird Care (Tonbridge & Tunbridge Wells) on 17 March 2017. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

This inspection was carried out to check that improvements to meet legal requirements planned by the registered manager had been made. We inspected the service against one of the five questions we ask about services: Is the service safe? This is because the service was not meeting a legal requirement in relation to this question.

The inspection was undertaken by one inspector. Before our inspection, we reviewed the information we held about the service. This included the provider's action plan, which set out the action they would take to meet legal requirements. We also reviewed the information we held about the service including any statutory notifications received. A statutory notification is information about important events which the provider is required to send us by law. We used this information to help us plan the inspection.

During our inspection, we spoke the registered manager, an operations manager, a supervisor, a coordinator and three members of the care team. We reviewed at 20 people's care records, their medicines management records and the medicines management policy. We also reviewed quality assurance audits in relation to medicines management and accidents and incidents records. We looked at staff files including training and supervision records.

After our inspection, we spoke with three people using the service and two relatives. We also received feedback from two healthcare professionals involved in people's care at the service.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection on 15 June 2016, we found that medicines were not managed appropriately. Medicine administration records (MAR) did not have sufficient information required for staff to administer medicines safely and were not always completed accurately. This was a breach of Regulation 12, Safe care and treatment of the Health and Social Care Act 2008 (Registration) Regulations 2014.

At this inspection of 17 March 2017, we found that the action taken to address our concerns was sufficient to meet the regulation. This ensured that medicines were managed and administered in a safe manner.

People benefitted from the improvements made to the management of their medicines at the service. The provider had introduced an electronic system for administering people's medicines to ensure any shortfalls were identified and resolved promptly. Staff were linked to the system on their mobile devices and had up to date information on each person's regular medicines and received alerts when there were any changes. The registered manager told us and records confirmed this had reduced the incidents of people not receiving their medicines. Staff signed an electronic MAR which informed the office staff when they had administered medicines. The system alerted office staff 15 minutes after the allocated time of administering if a person's electronic MAR remained unsigned. A supervisor told us they contacted the member of staff to find out the reason why and ensured they took the appropriate action. The registered manager and records showed this had reduced the incidents of people not receiving their medicines.

People told us and records confirmed they received their medicines when needed. MAR records were signed and completed accurately. Each person had a copy of their MAR kept in the office that reflected the one kept in their home. MARs contained details of people's medicines, the doses and when they were to be administered. Staff had information necessary to administer people's medicines appropriately. This ensured the service could be confident people received their prescribed medicines safely.

People were satisfied with the support they received to take their medicines. One person told us, "The reminders from staff are helpful for me to take my medicine." Another said, "I get my pills just about the same time daily." People had assessments completed to determine the support they required with their medicines. Staff had guidance on how to support each person with their medicines. Relatives were confident staff knew how to manage people's medicines safely and that they understood the support people required with their medicines. A relative told us, "Staff help [relative] to take their medicine. We have no worries about that." Another relative told us, "There was a mistake which staff identified quickly and their manager resolved the issue. It has not happened again." The person's care records showed the registered manager had worked with the relative who were responsible for ordering the medicines. This ensured that there were adequate stocks of medicine for the person.

People were supported to receive their medicines in line with the provider's policy on medicine management. A member of staff told us, "We only give prescribed medicines that are in their original packaging and with a label from the pharmacy. Other than that, we have to phone the office for advice." Staff told us and records confirmed they had received medicine management training and had their

practiced observed before they were signed off as competent. Staff had attended a refresher course on managing people's medicines in line with the provider's policy of which stated once every three months or when a manager identified a gap in their skills or knowledge because an error in administering.

People received appropriate support with their medicines. Supervisors carried out spot checks and observed how staff managed people's medicines. Records of spot checks showed that staff received feedback about their practice, for example, where gaps were identified on MAR charts, they were called to the office where the issue was discussed. The registered manager had made a referral to the safeguarding team on a medicine error at the service so that an investigation could be carried out because of a medicine error.

The registered manager and supervisor carried out checks and audits of MAR charts and record keeping ensuring people received their medicines as required. The audits showed improvements in practice regarding the recording of medicines people had taken. For example, a January 2017 audit identified that a person had not signed medicine consent forms. Another audit in March 2017 showed that "live in carer to make adjustment to MAR chart following doctor's visit. New MAR chart to be sent out." Their care records showed this had been followed up and done. The management team held weekly meeting to discuss any shortfall identified in medicine errors and put action plans in place to prevent a recurrence. There was an up to date policy and procedures in place to support staff and to ensure that medicines were managed in line with current regulations and guidance.