Factor of Four Ltd

Bluebird Care Ferndown

Inspection report

Unit B4 and B5, Arena Business Centre
9 Nimrod Way, East Dorset Trade Park
Ferndown
Dorset
BH21 7UH

Tel: 01202977200

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This announced inspection took place on 29 and 30 November 2016.

Bluebird Care Ferndown is registered to provide personal care to people living in their own homes. At the time of our inspection, the service was providing support to 42 people.

There was a registered manager who had been registered at the Ferndown office since October 2016 they covered two Bluebird services which included the Ferndown office and one other local office. 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.
The management team had gone through a period of change and had not had time prior to our inspection to complete improvements which they had identified. The registered manager was relatively new in post and told us they had inherited problems some of which they had actioned. For example they had addressed gaps in staff training. They had also contacted people to ask for their views on the electronic recording system as well as held meetings for staff to share information and listen to staff views. However, there were gaps in the quality of the electronic care plans and people and staff continued to express concerns about communication and changes to schedules. The registered manager was aware of this and had developed a form to update people on changes to their schedules however these measures had not had time to be fully embedded. The operations manager was also new in post; they told us how they planned to make improvements such as valuing and rewarding staff in order to create a stable and consistent staff team. However there had not been time for them to carry out these developments. Staff changes were continuing at the service; the supervisor was leaving the week of our inspection and the coordinator had been promoted to take over the supervisor role. Recruitment for a coordinator was underway.

The supervisor and coordinator provided on call cover in the office and covered visits when staff went absent at short notice. This meant there were times when there was not anyone available in the office to take calls or phone people to inform them if there were staff changes or if staff would be late with visits

There had been a turnover of staff that had been noticed by people and other staff. The registered manager explained there were valid reasons for staff leaving and one member of staff told us they were leaving as part of a carer progression. However another member of staff told us they were leaving as they did not feel they could achieve a good work life balance due to the demanding hours of the job. This meant that while people were supported by staff who knew them, they had to adjust to changes in the staff team when staff left. At the time of our inspection over half the care staff had been employed by the service since July 2016.

Some people were satisfied with the time keeping and scheduling of care staff. However four people and two staff told us that communication was poor and people and staff schedules were often not the same which meant the member of care staff who turned up was not always on people's schedule.

People generally considered staff to be caring although one person felt some staff just came and did the tasks identified and didn't chat with them. Another person described the attitude of a temporary member of staff as uncaring and they had asked that the person did not visit them again. Another person was trying to contact the service for help but could not get through. They told us the service told them later their request was not a priority; they considered it was an uncaring attitude. Other people told us particular care staff were excellent. One told us they had lots of laughs with care staff, another told us care staff treated them as if they were their mum.

New staff undertook an induction period which they told us was good and provided them with the right skills for the job. Although one relative told us they would like all new staff to receive training in stoma care so they had the right skills to support their relation. They told us on two occasions they had to show staff themselves. We talked with the registered manager who told us they would address this in future staff inductions. One member of staff told us they had been very well supported by the office staff who had contacted them frequently while they were settling into the post.

People were at reduced risk of harm. Staff were able to describe to us how they would recognise actual or potential abuse and how they would report it. People had their risks assessed and plans were developed to minimise the risk of them coming to harm.

People told us care staff supported them in their preferred ways and people were involved in planning their care. People were contacted by the office staff to check how their care package was going and if changes were needed. Formal reviews took place at least six monthly or sooner if needed.

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 was safe.

People mostly received their planned visits. Missed visits were monitored and investigated.

People were at reduced risk from harm and abuse. Staff had received training and were able to tell us how they would recognise abuse and how they would report it.

People's risks were assessed and plans developed to minimise their risks.

Staff prompted people with their medicines and there were measures in place to ensure people received their medicines correctly.

Is the service effective?

Good

The service was effective.

People were cared for by appropriately trained staff.

Staff sought people's consent before supporting them with care. Staff had received training and had an understanding of the Mental Capacity Act 2005 (MCA).

Staff communicated with healthcare professionals when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.
People had mixed views on their experience of care staff. Some people described staff positively and told us staff were excellent. However three people were negative about some staff.

People were not always kept informed to changes in their schedules.

Staff were able to check people's electronic records before visiting them which enabled them to be up to date with the persons' care records.

People had their privacy and dignity maintained.

People and their relatives were involved in decisions about their care.

Is the service responsive?

Good

The service was responsive. People's care plans were being transferred to an electronic system which gave clear prompts to staff on which tasks they needed to carry out for the person. People's views had been sought and people could retain paper care plans in tandem if they chose to.

Concerns and complaints were managed appropriately and responded to in line with the provider's complaints policy.

Is the service well-led?

Requires Improvement

The service was not consistently well led.
The management team had undergone change and was relatively new. They had not had sufficient time to robustly and consistently make improvements.
There were systems in place to monitor the quality of the service and improvements were on-going.

Bluebird Care Ferndown

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 was announced and took place on 2016. Further phone calls were completed on 2 December 2016. The provider was given 24 hours' notice because the location provides a domiciliary care service to people in their own homes and we needed to be sure that someone would be at the office and able to assist us to arrange home visits.

Prior to the inspection we requested and received a Provider Information Return (PIR). A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also considered information we held about the service which included notifications regarding safeguarding, accidents and changes in the service.

We spoke with three people and one relative in their homes. We also telephoned six people and one relative to obtain their views about the service. We spoke with eight staff which included the registered manager, the operations manager, supervisor, coordinator and four care staff. We looked at four care plans and three staff files. We also spoke with one healthcare professional and contacted a representative from the quality improvement team. We saw four weeks of the staffing rota, the staff training records and other information about the management of the service.

Good

Is the service safe?

Our findings

There were enough staff to meet people's assessed needs. However one member of staff told us travel time between visits was not always sufficient which meant that they did not arrive at all their visits on time. One person told us care staff did not always arrive on time. Another person told us that care staff were sometimes late but said "They can't help the traffic." Another person told us "They usually phone me if they're going to be late." One person and a relative told us that staff did not rush their visits and carried out the tasks that were identified in the person's care plan.
People's schedules were developed electronically and we were told that time is factored in for road works and peak periods.

There was a missed visits report dated 1 November 2015- 31 October 2016. There had been eight missed visits recorded in that period. Actions arising to address this were for office staff to receive training in staff planning and also all new office staff to receive training in on call strategies before being on call. The registered manager told us they monitored missed visits closely and investigated each one as it occurred. For example they told us one missed visit was as a result of one staff being absent from work because of sickness. The schedule was changed and a member of staff did not read their updated schedule. We saw this had been addressed with the member of staff.

There were sufficient pre- employment checks to ensure that staff were safe to work with vulnerable adults. For example references were obtained and checks were made with the Disclosure and Baring Service (DBS).

There was a business continuity plan which detailed steps to ensure there was adequate staff cover. This included a customer priority tool for emergency planning at the service. This focussed on how the service would support people in an emergency, for example severe winter weather or a flu pandemic. There was a system which prioritised people who were living alone or had more complex needs. This meant that the most vulnerable people would not be left without the care they needed.

People and relatives told us they felt safe in the care and support they received from the service. One relative told us their relation had risks associated with skin damage and needed particular care which was variable. They were confident care staff supported their relation in a way which reduced the risk of skin damage.

People's risks were assessed and plans developed to ensure care was provided safely. For example one person was at risk falls, their care plan provided guidance for staff about how to support the person to reduce their risk of falling. They reduced the risks by ensuring the person used the correct mobility aids, ensuring the home was free from trip hazards and reminding the person to wear their life line.

People received their medicines as prescribed. The service had recently moved all medicine recording to an electronic system and staff used smart phones to record when they prompted or administered medicines. We saw that staff recorded accurately and the electronic system would alert the office if a medicine was not given. There were regular checks on medicines to ensure that errors were identified and actions taken to resolve them. Staff received training in medicines and were assessed during their induction period to ensure

they were competent to prompt people with their medicine.

People were at reduced risk of harm and abuse. Staff had received training in safeguarding vulnerable adults and were able to describe to us how they would recognise abuse. Staff were aware of the correct processes to follow in order to report abuse, including how to report concerns about poor practice.

Good

Is the service effective?

Our findings

People were confident that staff had the right skills to carry out their jobs. The registered manager told us they had identified gaps in staff training. They showed us the actions they had taken to address this, such as emails to staff and evidence that training had been completed. Staff were required to complete training in a range of areas. For example medicine awareness, basic life support and fluids and nutrition. Training was provided by either e-learning or face to face. The operations manager told us that following analysis of complaints received training was being organised for staff on communication including communication with people living with dementia.

The service had a framework for induction, supervision and appraisal of new and existing staff. New staff received an induction into their role and they were supported to enrol on the Care Certificate. This is a set of standards that social care and health workers stick adhere to in their daily working life. They are a set of minimum standards that should be covered as part of induction training of new care workers. During induction new staff received face to face supervision in the office and during visits with people. They were observed carrying out their job roles in order to assess their competencies in the role. Following completion of the probation period staff continued to receive regular supervision and an annual appraisal. One member of staff told us their induction was good and they felt supported in their new role. .Another member of staff told us they felt like they were supported during their induction and felt like they had their own personal link to the office. Staff felt supported in supervision and told us they were invited to make suggestions and felt listened to. One relative told us it would be helpful if new staff completed training on stoma care as part of their induction as they had to show two new staff how to provide stoma care. We spoke with the registered manager who agreed they would arrange for this training to be included in the induction.

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 by 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. Staff received training in the MCA and were able to explain to us how they obtained consent and we saw that people's capacity was assessed during their pre assessment. We saw that people had consented to their care package. Staff were able to describe to us the correct processes they would follow if they needed to provide support to a person in their best interests.

People were supported with food and drink. They had nutritional assessments and staff explained to us how they ensured people had sufficient to eat and drink. One member of staff told us they prepared meals for one person and they checked on the next visit if the person had eaten the meal. Another member of staff told us they always asked people what food they would like and checked they had what they need before leaving. They told us they ensured people had drinks easily accessible, which we saw during our visits.

A healthcare professional told us they had confidence in the service carrying out recommendations such as

correct use of moving and assisting equipment. The registered manager told us they communicated with district nurses when needed and one person confirmed staff adjusted their care plan when they experienced changes to their care and treatment because of health issues.

Requires Improvement

Is the service caring?

Our findings

There was mixed feedback from people about how caring they believed the staff were. People were generally positive about staff who supported them although three people told us the care they received was inconsistent. For example one person told us one of the care staff was excellent and described others as alright. They told us the difference was some staff came in and talked with them and other care staff "Don't have a conversation, just come in and do the job." They told us they lived alone and felt isolated, they looked forward to visits from care staff and it was important for them to have a chat with them. Another person told us they experienced the attitude of care staff on one occasion as uncaring. They had been unable to get through to the office to request something. When they spoke with a member of staff about this they told us they were told this wasn't a priority. A third person told us they experienced a temporary member of staff as uncaring, and they were unhappy with comments the member of staff made. They addressed this with the office and the person has been blocked from visiting the person again. However the remaining people we spoke with were complimentary about staff. For example one person told us about one member of care staff who they described as excellent and told us they always had a smile for them and was always helpful. Two other people were particularly positive about two other members of staff. Another person told us "They are so amenable, we have so much fun, lots of laughter, which probably says it all, and someone else commented that staff treated them as if they were their mum."

People did not always feel they were communicated with by the service. For example one person told us it was important for them to know who which member of care staff was going to be supporting them. They found it unsettling when a change to their schedule was made without being informed. A member of staff told us there were problems with communication and that the schedules got changed without people being informed. We spoke with the registered manager who was aware of issues related to scheduling and had identified it as an area for improvement. One of the actions they had taken was to develop a form to send to people to alert them to changes in their schedule.

We saw staff engaged positively with people and talked with them informally about their day and plans people had in a way which demonstrated that people were relaxed with them. One person had developed a rapport with a member of staff and was disappointed they had resigned from their job. They told us they had common interests and looked forward to the conversations they had.

Staff were able to describe to us how they supported people to maintain their privacy and dignity. One member of staff told us they were respectful of entering people's homes and always checked with the person where they wanted to be supported with personal care. They told us that when they could access peoples home via a key safe they always called out to alert the person they were coming in. They told us they closed curtains during personal care and did not leave people exposed unnecessarily. One person told us they felt staff were respectful of their privacy and dignity.

People and their families had involvement in decisions about their care. People were involved in a pre-assessment of their care and support needs and their care plan was developed in collaboration with them.

One person told us they told the service how they wanted their care provided and felt involved in making changes to their care plan when it was needed.

Good

Is the service responsive?

Our findings

The service had moved to an electronic system in July 2016 and all files were accessed remotely via smart phones held by staff. Each person had a paper copy of their care plan in their home and these were in place at the homes we visited. The registered manager told us that electronic care plans were still being completed; they had achieved 75% at the time of our inspection. They explained that people's original paper care plans were still in in use while work on electronic care plans was continuing. We saw some variables in the recording of people's care plans on the electronic system such as some people's summaries were too brief. This meant that care plans provided a list of tasks but did not always provide personalised information about the person. One member of care staff told us they would like more information about new people before visiting them. One person we spoke with told us they were happy with the service and told us staff supported them in their preferred way. They explained they talked with staff who went to great lengths to get the care right. Another person told us that care staff do everything just how they like things done. During our inspection we saw care staff constantly checking with people in what way they wanted tasks carried out.

One person had a detailed plan which gave specific details on how they wanted staff to support them. For example they preferred their bed to be made in a particular way and liked things stored in the cupboard in a certain way. Staff were given clear guidance on the person's preferences. Staff respected this and followed the care plan and one member of staff told us "It's their house, how they want things, that's what we are here for."

Daily care records were completed by staff on the smart phones and could therefore be seen in the office. The system identified tasks staff should complete for each person they visited. An alert was raised in the office if a task was not completed. This reduced the risk of people not receiving the care they needed.

The registered manager told us they had written to people to ask if they were happy with this system and if they required further information. They were also offered the opportunity to retain daily paper records in their own home. Five people were continuing with paper records in tandem with the electronic system. People, or an appropriate other, could also sign up to have access to their electronic records. Of 39 returned responses, 11 people wanted more information. The registered manager told us they had contacted people by phone to provide more explanation. Nine people had requested access to the electronic record and the registered manager told us this had been activated. This showed us that the service sought people's views on changes within the service and that people's views were listened to and responded to. People had paper copies of their care plans in their homes which meant that if there were technical problems staff knew what care and support people needed.

Staff told us the electronic system made it clear to them what they needed to do during visits for example if a person needed support with personal care or if they needed to apply cream for a person. One member of staff told us another benefit was they could read people's care notes before they visited so that they had an understanding of the person's needs, preferences, routines and any other updates before entering the house. Another member of staff described being able to do homework prior to visits which gave them

confidence to carry out their job.

People told us that the office staff rang to check how they were and if changes were needed to their care plan. They told us they felt listened to by the service. Formal reviews took place at least six monthly although were arranged sooner if needed. One person had requested a review during our inspection and a member of staff had arranged a meeting to take place in the person's home. One person told us they had requested a review to take place the following week. This showed us that the service was responsive to people's request for a review.

Concerns and complaints were managed appropriately and according to the provider's complaints policy. The registered manager told us there was a twice yearly review of concerns and complaints which they monitored to ensure they were managed appropriately and if there were any common themes. We saw three complaints had been received in the last 12 months. A common theme was communication in particular with people living with dementia. An action to improve this was to enrol staff on training. Compliments had also been received. For example one relative wrote to staff to give thanks for supporting their relation to remain in their own home.

Requires Improvement

Is the service well-led?

Our findings

The management team had undergone change. The registered manager was also registered manager of another local office and had been the registered manager at the Ferndown office since October 2016. This meant they were covering two sites and the day to day management of the service was carried out by a supervisor, a co-ordinator and an administrator. The operations manager was also new in post. The supervisor was leaving their position during our inspection and the coordinator had been promoted to supervisor. Interviews were underway for a replacement coordinator. This meant the management team had not had sufficient opportunity to maintain consistent leadership. One member of staff told us that the management of the service was improving and they were confident the service was moving forwards.

People generally reported that they could access the office for support. However two people told us that there were times when they could not get through to someone in the office. One person told us on one occasion they had to go to a neighbour for help instead. A member of staff told us that the supervisor or coordinator provided on call cover. This meant if staff had unplanned absence the on-call supervisor or coordinator would need to provide care for people in place of the scheduled care worker. This also meant if the supervisor was on visits they were unable to telephone people to either alert them to a change in care worker and also if there were any timing implications. This showed us that office cover was inconsistent and people could not always access the office when they needed.

The care staff team had also gone through a period of change. The registered manager told us that six out of nine care staff had joined the service since July 2016.They told us there were varied reasons for staff leaving. At the time of our inspection two staff had resigned and were due to finish working in the service that week. One member of staff who had resigned told us they wanted more regular hours and they wanted to achieve a better work life balance. They felt this could not be achieved in their role within the team. Another member of staff who had resigned told us they had started worked for the service to gain some experience prior to moving on to another job which they considered to be a career progression.

The operations manager told us one of their key priorities was to develop a stable workforce. They planned to approach this in a number of ways. For example they wanted to foster a culture of caring for carers (staff) and create a pathway of personal development, in order to support staff through training. They considered it important to value and reward staff in the good work they do.

Quality assurance systems were not consistently effective. Auditing included monthly checks on staff recruitment such as number of interviews, number of new staff, numbers of care files audited and numbers of staff supervision. The registered manager told us these checks helped them identify where improvements were needed. For example an audit of care plans and review dates showed two were overdue. Actions had been taken to book the reviews. We spoke with the registered manager about people's care plans which varied in detail. The essential information had been captured however some care plans provided more personalised detail about the person. This had not been identified as part of care plan auditing which meant the quality of care planning was inconsistent.

People and staff received quality questionnaires. 20 returned questionnaires from people in January 2016 showed that people were mostly satisfied with tasks being completed at each visit and most people had received information about the service. However 20% of people were not informed if staff were going to be late. A quality survey was carried out again in September 2016 by telephone. Feedback was mostly positive although one person did comment about staff being late. An action was taken to notify people when their schedules changed. During our inspection people told us they had not been notified about changes in their schedules and people received late visits which showed us that areas for improvements had been identified however actions to address them had not been effective.

Staff in the office were clear about their individual roles. The supervisor explained they were involved in meeting with people to carry out a pre-assessment and to establish if the service could meet their needs. They also had responsibilities for staff supervisions and spot checks and completing peoples care and support plans. They described the office as having an open door policy and felt this was important in supporting staff. The coordinator responsibilities included planning the schedules. They explained travel times were calculated electronically and extra time was added on for road works. They agreed there were sometimes glitches in the system and when this happened they talked with people and staff to offer an explanation and apologise. Staff received their schedule via their smart phone on a daily basis. The operations manager was new in post they covered more than one site and told us their key priorities included ensuring the service was meeting the expected standards.

The registered manager had submitted notifications to the CQC as required. The provider is legally obliged to send us notifications of incidents, events or changes that happen to the service within a required timescale.

The registered manager told us they used different methods to communicate with people and staff. This included quality questionnaires, staff meetings, newsletters and they planned to organise an informal Christmas meet and greet. They told us they considered it to be important to improve communication .Meetings with staff were organised to ensure information was communicated and staff could discuss issues. For example meetings had been held for managers in November 2016 and all staff in October 2016. During staff feedback staff had reported that drive times between some visits was not calculated correctly and did not allow enough time to get to visit people at the time arranged.

Staff told us they felt supported by the registered manager and were able to contact the office whenever they needed to talk about any concerns they had.