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Bluebird Care (Kensington and Chelsea)

Inspection report

76 Pembroke Road
London
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14 June 2018

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out this announced inspection on 13 and 14 June 2018. Bluebird Care (Kensington and Chelsea) is a domiciliary care agency and a franchisee of Bluebird Care. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults and younger disabled adults.

At the time of our inspection this service was providing personal care to 60 people in the Royal Borough of Kensington and Chelsea. Not everyone using this service receives 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.

At our last inspection in August 2016 we rated this service 'good'. At this inspection we found the service remained 'good'.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had effective systems to assess people's care needs and to plan their care in a way which met their needs. Care workers used an electronic system to record the care people needed and to demonstrate how they had provided this. Care plans were reviewed frequently as people's needs changed. People had consented to their care and the provider made sure that people's capacity was assessed and that care was delivered in people's best interests.

People's medicines were managed safely. This included assessing the support people required and operating an electronic record of medicines support. Records were checked regularly by managers to ensure that people received their medicines as planned. Where there were risks to people's safety these were assessed by the provider and suitable mitigation plans were in place, including those relating to moving and handling needs. When incidents had taken place or complaints received, managers acted on these and investigated what had taken place, and were able to learn from when things had gone wrong.

The provider operated safer recruitment measures and carried out appropriate training and spot checks to ensure that care workers were suitable for their roles and had the right skills to care for people. Care workers arrived on time and managers used an electronic call monitoring system to protect people against missed and late visits.

People told us that they were treated with respect by care workers. There were measures in place to ensure that care workers understood how to promote people's dignity and this was regularly checked by managers. Care workers were able to promote people's health by observing when a person appeared unwell or in need

of additional support and took the right action to address this.

The service took account of people's cultural needs and provided the right information to care workers to ensure that these were met. People received support to make sure they had enough to eat in a way which met their cultural needs and their preferences. The provider had measures in place to protect people from the risk of dehydration.

People had regular reviews of their care and managers monitored people to make sure that they happy with the standard of care provided. Staff told us they received the right support from managers.

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 remained good.	**Good**
Is the service effective? The service remained good.	**Good**
Is the service caring? The service remained good.	**Good**
Is the service responsive? The service remained good.	**Good**
Is the service well-led? The service remained good.	**Good**

Bluebird Care (Kensington and Chelsea)

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.

Why we inspected – This was a routine inspection as we rated this service 'good' in August 2016. However, we brought this inspection forward as we had received some information of concern about this service. We were aware of one safeguarding allegation regarding alleged financial abuse; we confirmed with the provider at the time that they had taken appropriate action to report and investigate this.

Prior to carrying out this inspection we looked at information we held about the service, such as notification of serious incidents that the provider was required to tell us about. We also asked the provider to complete a provider information return (PIR). This is a form which asks the provider to tell us what they think they are doing well and their plans to develop the service. We also spoke with a contracts manager from the local authority.

This inspection took place on 13 and 14 June. and was announced. We gave the service 48 hours' notice of the inspection visit because it is small and the registered manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

The service was carried out by a single adult social care inspector with an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

In carrying out this inspection we spoke with the director, care manager, deputy care manager and training co-ordinator. We looked at records of care and support for six people who used the service and records of

medicines management for five people. We looked at rotas for eight care workers and records of electronic call monitoring for six people. We looked at records of recruitment and supervision for six care workers and records relating to the management of the service, such as audits, training records, policies and staff communications.

After the site visit we made calls to eight care workers, 11 people who used the service and two relatives of people who used the service.

Good

Is the service safe?

Our findings

People who used the service told us that they felt safe when their care workers visited. Comments included, "They make me feel safe in my environment and when out walking" and "I would call the Bluebird office if I didn't feel safe."

Staff received training in safeguarding adults and were clear about their responsibilities to detect and report abuse. Care workers told us that they thought their managers would take it seriously. One care worker told us, "Of course they would take it seriously. They would launch an investigation." The provider had a suitable safeguarding policy that was clear about how to identify forms of abuse and the responsibilities of care workers and the registered manager when abuse was suspected. When abuse had been suspected, the provider had acted promptly to inform the local authority and taken appropriate action to address the issue of concern.

When care workers handled money on behalf of people this was done in line with a financial support plan, which identified the support people required and possible risks associated with this. We saw care workers retained receipts and kept appropriate records to safeguard people against loss or theft which were checked by a manager.

The provider continued to undertake suitable assessments of possible risks to people. These included assessing whether people were at risk of falls or pressure sores, and undertaking an assessment of the safety of a person's home. When risks were identified there were clear measures to mitigate these risks. For example, when people wore pendants to summon help staff were prompted on each visit to confirm that they were wearing these. Where people were unsteady on their feet or needed support to mobilise, plans highlighted the risks associated with this and contained detailed information on how best to support people. This included information about how to support people who required hoists to make transfers. The provider had systems in place to check that moving and handling equipment was kept safe and well maintained.

The provider ensured that care workers were suitable for their roles by following safer recruitment measures. This included checking the identity of candidates, obtaining a full work history and proof of their right to work in the United Kingdom. The provider obtained two references from previous employers. This evidenced that where relevant people had good conduct in previous health and social care roles. However, we found that the provider's processes required managers to confirm that they had two satisfactory references, not whether these references evidenced satisfactory conduct in previous health and social care employment. This meant there was a possibility that the provider would not meet this condition in future. Prior to starting work, care workers had received a check with the Disclosure and Barring Service (DBS). The DBS provides information on people's background, including convictions, to help employers make safer recruitment decisions.

There were enough staff deployed to meet people's needs. We looked at the rotas of eight care workers over a seven day period, which spanned 226 visits. We saw that 93% of visits were scheduled with enough travel

time. Of the remaining 17 visits, four would have resulted in the care worker arriving between 30 to 45 minutes late. These were all on the same care worker's rota, who told us that their rota was manageable, and we verified with the provider that these visits were met without impacting on people's care. Comments from care workers included "The rota is manageable" and "If they don't have enough carers they have to squeeze the schedule. If [the registered manager] sees there's no way to get there on time she starts booking cabs."

People told us their care workers arrived on time. Comments included, "They arrive sometimes earlier than normal and they keep me up to date if they're running late" and "They have to check in and check out, so they're pretty accurate. Sometimes they arrive late, but they make up the time."

Care workers used an electronic call monitoring (ECM) system to record when they arrived and left a care visit. This was used by managers to ensure that care workers had arrived on time, and was used on all visits we checked. We looked at the call data for six people over a one week period. This showed that 90% of care visits were delivered within 15 minutes of the planned time.

When people were supported to take their medicines there was a suitable assessment in place for this. This included assessing the level of support people required, whether medicines aids such as blister packs were in place and any risks associated with the person's medicines, including allergies and storage of medicines. Care plans were clear about the medicines people took and the times and doses, but did not always explain what medicines were for and whether there were any possible side-effects care workers should be aware of. People had signed appropriate consent for care workers to support them with their medicines.

Care plans were used to inform an electronic medicines administration record (EMAR). This meant that care workers received a prompt on a handheld device stating which medicines should be given on each visit. Where people were managing their own medicines, this information was highlighted to care workers with a clear message that no support was needed. The provider told us "[The EMAR] is very good with antibiotics, as we can automatically set an alert to deactivate it. You're not relying on anyone's memory." The system automatically notified managers in real time if a medicine was not accounted for. We looked at three months of EMAR charts for five people who used the service and saw that medicines were suitably accounted for; typically, managers reviewed this every one to three days.

Where medicines had not been administered, care workers had recorded the reasons why, and this had been signed off by a manager. At times we saw that when more than one care worker was attending a single visit, all care workers were promoted to complete a record of medicines support. At times this caused confusion among care workers who recorded the same medicine more than once, however these mistakes had been spotted by managers and rectified accordingly and there was still a clear and complete record maintained.

Care workers had the right skills to administer medicines. This included providing regular training on medicines management and undertaking regular observations of staff competency, which were as often as weekly for some care workers.

There were suitable measures in place for recording when things had gone wrong. This included obtaining details of an incident or accident and recording what action had been taken in response to this. For example, when care workers had missed visits this had been recorded by managers and a detailed investigation had taken place into the causes, where appropriate this involved additional supervision, training or disciplinary action to be taken against care workers.

People told us that their care workers routinely used appropriate personal protective equipment to manage the risks of cross-infection. Comments included "(They use these) all the time" and They are constantly changing gloves." Care plans contained detailed assessments of the risks to people from cross-infection and how these could be managed by care workers.

Good

Is the service effective?

Our findings

People's needs and choices continued to be assessed by the provider. This included a detailed assessment of people's needs and living arrangements, any difficulties a person may be having and the impact that these had on the person. Assessments included information on the support people required with personal care, skin care, continence, grooming and oral care and information on what people could do for themselves and the level of support they required in these areas.

The provider ensured that care workers had the right skills to carry out their roles. This included undertaking the Care Certificate as part of their induction. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sector. It is made up of the 15 minimum standards that should be covered as part of an induction for a person who is new to care. Following their inductions, care workers undertook shadowing with more experienced care workers, and records were maintained of this, including whether further training needs had been identified.

Care workers received refresher training in key areas such as communication, privacy and dignity, mental health and dementia, moving and handling, fire safety, infection control and safeguarding. These were monitored by managers to ensure that care workers remained up to date. Training materials were detailed, for example moving and handling training contained clear information on what was an unsafe or unsuitable lift and highlighted the need for care workers to check the safety of equipment provided for this purpose.

Care workers we spoke with told us they found training useful. Comments included "The training is the best thing in Bluebird, the training is so good", "We have the best trainer ever" and "They have regular refreshers as well so you're kept up to date on what you need to know".

Managers carried out regular spot checks of care workers to ensure that care was delivered to a suitable standard. This included checking that care workers arrived on time, wore the correct uniform, communicated well with people and worked in line with the person's care plan. Managers typically carried this out every two to three months, but care workers told us that this was carried out more frequently for newer staff. A care worker told us "They see how I'm doing, how I communicate with the client and am I wearing my uniform. If they see something that I've done wrong they'll either correct us or say do you think you need more training or a refresher?"

Care workers received regular supervision meetings with managers. These were recorded on the rostering system, but at times lacked detail on exactly what was discussed. For example, we saw supervision that gave a summary of points discussed as "roster, the work" and another which read "Discussed: the role of the care worker. Roster and time between visits: co-ordinator will be informed." It was not always clear whether care workers or supervisors had highlighted concerns and what action was taken in response to these.

People were supported to stay well. Plans included information about people's medical diagnoses and how they may affect the person. Care workers had recorded when they had reported concerns about people's health and the actions they had taken in response to these. This included contacting emergency services,

GP services or arranging for referrals to occupational therapists or district nursing, and reporting to social workers when people had refused personal care for a number of days. Comments from people and their relatives included "They give me good advice to stay well", "They're very attentive of my wellbeing" and "[My relative's] health went downhill; one carer was bathing him and she told me that my [my relative] needed to go back into hospital; we called 111 and [they] went back in".

People received support with nutrition and hydration. People told us they had the right support with meals. Comments included, "They help with breakfast and they give me ideas on how to prepare meals, which I wasn't doing before. They've steered me towards a healthy balanced diet. They helped make things easy and understandable", "They give [my relative] a choice of what she wants; she's never complained of bad food" and "They're always asking me if I'm ok or do I need water."

When people required support to eat and drink this was highlighted in a nutrition and hydration care plan. This included detailing food allergies, people's likes and dislikes, the level of support they required with food preparation and consumption and who was responsible for preparing food. Records of care provided contained detailed information on what people had eaten for each meal and showed people received balanced diets in line with their wishes. The provider had also added an additional measure to protect people from the risk of dehydration. This involved adding an additional prompt to each visit plan for care workers to record whether a person had had fluids during their visit and whether the care worker had left out a drink for them. We saw that this was being completed by care workers with details on each visit of the drinks people had been provided with.

The provider continued to work in line with the Mental Capacity Act (2005) (MCA). The Act 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. When a person may not have capacity to make a decision, the provider had assessed their capacity in line with best practice and considered the support people required to make decisions for themselves. Where appropriate they asked a family member to sign as a best interests representative. Where a family member had a power of attorney, the provider had a process to check that this was valid before they could sign a care plan on behalf of the person.

Good

Is the service caring?

Our findings

People told us the service was caring. Comments included "They're just very amiable and look after me well", "They are so kind and really helpful" and "They always listen to us."

There were systems in place to listen to people's views. This included carrying out regular reviews and customer satisfaction checks. Customer satisfaction checks involved contacting the person or a relative to ask how they were finding their support and whether anything needed to change. People also told us that they did not feel rushed by their care workers. Comments included, "They spend quality time with [my relative]" and "They take their time and I don't feel rushed at all."

People were also asked to give feedback on their care workers and whether they were happy with the care provided. There was a system in place for recording which care workers could work with which person. In the event of a complaint or an issue arising which would result in a care worker being removed from a person's package of care, a note would be added onto the computer system which would prevent the care worker from being allocated to that person in future.

We saw examples of people complimenting the service for being caring. For example, one person had written to the registered manager to thank them for sending their relative flowers when they were in hospital. The provider told us they tried to do this wherever possible. In another example, a person had thanked the registered manager for offering to move their laundry visit to a different day to avoid them having to pay a bank holiday rate.

People's plans contained detailed information about their life stories, preferences for their care and their religious and cultural needs. For example, one person's plan contained clear information about how they were supported to keep kosher, and which foods in the house were kosher and which were not. This information was also put on the daily record and staff rotas so it was easily accessible. Plans also had considerable detail about people's preferences for their care, such as how they preferred to bath, and times when care workers should give a person space to do things for themselves, such as washing their hands and face. There was information about what people could do for themselves and how this could best be promoted by care workers.

Plans also contained information about how people could be supported to make choices, their family backgrounds and personalised information such as the names and types of pets they had. The provider gathered information about how people communicated, including how they could express themselves through body language and the support they may require with communication, including the use of glasses and hearing aids.

People told us that care workers treated them with respect and protected their privacy. Comments included "They respect my belongings and my wishes", "They're polite and caring" and "We have a mutual respect, it works both ways." Care workers received training on promoting privacy and dignity as part of their induction and refresher training, and were assessed through regular spot checks for whether they had treated the

person with respect and maintained their dignity.

The provider had measures in place to promote confidentiality. For example, electronic care plans and notes were available through mobile devices, and these were only accessible with the use of a password, which could be easily revoked by the provider should a staff member leave the service. People's care folders contained information on how a relative or friend could access care notes, but the provider's policy explained that this would only take place once the registered manager had permission from the person to share those notes. The provider told us "Families want to monitor how their family members are doing, and this system is accessible."

Good

Is the service responsive?

Our findings

People told us that they were involved in planning their care and that the service was responsive to their needs. Comments included "I feel very comfortable and secure that they will do what I want. They know my routine so I don't have to tell them every time" and "I know what's in [my care plan] and was involved from the beginning." One person said "There are times when I've needed extra time and it was accommodated by the agency."

The provider used an electronic care planning and recording system. This involved drawing up a list of outcomes for the person, such as how they could remain independent in their own home and maintain their hydration and personal care. This was then used to generate a list of tasks for the care worker to follow on each visit. Care workers used these as the basis of daily notes in order to record what they had done for the person and if there were any changes to their needs.

Small changes were made to the care plans we reviewed on a weekly basis. The provider told us "Imagine that last week they loved tea now they prefer coffee. That's an instant change we can do and that way people get the care they want." A care worker told us, "The system is excellent. If you need to see what the previous carer did you can do that on the way and prepare yourself and see if there are changes. When we used a folder you couldn't pay attention to your customer." Larger changes had also been included in care plans, for example adding an extra visit when a person's care needs had changed. A care worker told us "[My customer] starts getting weaker, and I said I think you guys need to do an extra visit. They came out and assessed [them] and it was in place by tea time."

We saw that when tasks were identified for visits, these were routinely completed by care workers, with further details included on how care had been provided, for example whether a person had had a shower or a strip wash, and whether a person had independently carried out their care or refused it. For all the care plans we reviewed we saw that care had been delivered as planned. Where care was declined, or carried out independently by the person care workers had checked and recorded this accordingly.

The provider assessed whether people had difficulty with reading and accessing information, and care plans were clearly presented and frequently used symbols, in a way which met the Accessible Information Standard. The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with AIS.

The provider carried out six monthly reviews of people's care packages. This included checking whether people were happy with the care they received and assessing whether any changes were needed to the care plan. Sometimes reviews did not contain detailed information about the discussions that had taken place, but when changes were identified these we carried out.

The provider had a system in place for monitoring concerns and complaints about the service. People told us that these were addressed promptly. Comments included "Once or twice one of the carers was really late

and my [relative] got very upset. I called the Supervisor and they apologised and explained; since then it's not happened" and "One carer refused to do some chores, which were part of the care plan; I complained to the manager and the carer was removed." The registered manager recorded when complaints were received, what the person's preferred outcome was and whether these related to staff conduct or performance or to a safeguarding matter. We saw that complaints were investigated and actions taken in response to these were recorded.

Good

Is the service well-led?

Our findings

People told us that the service was well managed. Comments included, "[The manager] is very good", "She came here to see that all was okay with the care when [my relative] came out of hospital" and "She constantly keeps in touch".

Staff told us they felt well supported, but at times communication had been poor and that they felt the office staff were too busy, but that this had improved in recent months. A care worker said, "It's a good company but some things are lacking.", "[It's] the sheer turnover of staff in the office. They're changing over so much as they are stressed out all the time" and "Sometimes the communication used to be a bit bad, but now it's not bad." The registered manager told us "I'm aware of some ways that we have to develop. For a while we were extremely short staffed [in the office]. We are hiring for a second co-ordinator and a customer services manager." Other comments from care workers included, "Yes they are very supportive. If we need something we can call them and we have an on call out of hours", "I've never had a time that managers weren't available".

We saw times when spot checks had reduced in frequency, for example one staff member had not received a spot check for a seven month period, but this had since improved and was now taking place regularly. The registered manager told us, "We did have gaps there, the supervisors weren't managing." Office staff supervisions were taking place monthly; at times staff members had voiced their concern about their workload, but we could see that the provider had recruited more staff in order to make this more manageable.

The provider had systems in place to ensure prompt audits. The electronic notes system allowed logs and medicines records to be checked frequently, usually this was taking place twice per week. In addition to this, the provider had carried out audits on people's care records and on care worker files. This included checking that care plans were up to date, consent was provided to care and that risk and medicines assessments were in place. Care worker files were checked to ensure the required information was held about care workers and that there was evidence of shadowing and up to date training and supervision. Where documentation was missing or incomplete action had been taken in order to address this.

The provider had also carried out an audit in order to assess their compliance with the General Data Protection Regulations (GDPR). This included considering what personal information the provider held on people using the service, care workers and applicants, assessing who had access to information and whether it was held securely with appropriate consents in place.

The provider had carried out an equality and diversity impact assessment. As part of this they had considered whether their service was accessible and well known amongst people from black and minority ethnic (BME) backgrounds and whether the service was meeting people's needs relating to their religion and culture. The audit had also considered how they could ensure people with disabilities could access the service, including whether information needed to be provided in other formats. As a result of the audit, the provider had identified local organisations they could work with in order to improve people's access to the

service and were recruiting a community engagement officer in order to work on this.

The provider also had a continuing quality improvement plan. This looked at ways the service could develop, for example to improve recording systems and adopt paperless systems and how to provide new apps and software for care workers to use.

There were systems in place to promote staff communication. This included being able to send information to care workers when a task was required, such as picking up medicines. Care workers had access to policies and procedures through their mobile handsets, and the provider told us they could compile a reading list to ensure people remained up to date with current requirements. There was also a newsletter in place to ensure people understood the provider's expectations, such as those around confidentiality.

The provider also showed us other incentives they had offered care workers. This included a long service dinner for care workers who had worked with the service for four years or more, a spa day in the office and parties to mark Christmas and Halloween. Care workers had also been given the opportunity to attend self-defence classes.