Blueboard Care Services Ltd

Yewtree Avenue

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Yewtree Avenue (known as Blueboard Care Services) is a domiciliary care agency registered to provide personal care. At the time of the inspection 88 people were receiving care.

People's experience of using this service and what we found
Medicines were not managed safely. Medicine risk assessments did not contain enough information and medicine administration was not being quality assured satisfactorily. Risk assessments were not always completed correctly or contained contradictory information.

There were systems in place to safeguard people from abuse and lessons were learned when things went wrong. However, CQC were not always notified when allegations of abuse were made and one incident had not been recorded as such. People and relatives had mixed views about call times and staff having enough time to do their jobs.

Infection control measures were in place. Recruitment measures were robust.

There were mixed views about the communication from the service as well as about how it was managed.

People spoke positively about the care staff. The service worked with other agencies for the benefit of people using the service and we saw positive feedback about the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 22 May 2020).

Why we inspected
We believed there was risk present at the service due to the number of factors including complaints we had received about the service in the past 12 months. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took

account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Yewtree Avenue

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors and one 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.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave a short period notice of the inspection. This was because we needed to be sure that staff would be in the office to support the inspection.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority and professionals who might work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection

We spoke with six people who used the service and six relatives about their experience of the care provided. We spoke with four members of staff including the registered manager, the compliance manager, the deputy manager and the care coordinator for the service.We reviewed a range of records. This included eleven people's care and medicine records. We looked at six staff files in relation to recruitment. We also looked at a variety of records relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. This included speaking to the compliance manager and four care staff. We looked at further evidence sent to us by the provider which included one more person's care and or medicines records, as well as documents relating to medicine management and staff engagement.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- The management of people's medicines could be improved. We looked at three people's risk assessments for medicines and also quality assurance measures for medicines management. We found they did not always contain specific detail which would ensure safe management of medicines or provided conflicting information.
- One risk assessment indicated four medicines were being prescribed. There were risks identified with these medicines, but these were minimal and did not highlight all the risks associated with each medicine.
- For example, one medicine Fluoxetine, was being prescribed. Fluoxetine is an anti-depressant medicine often referred to as Prozac, which can be prescribed for depression, but also other conditions related to mental such as bulimia and obsessive-compulsive disorder. Some people shouldn't take it, such as those who are pregnant or have heart conditions and there are side effects such as headaches and trouble sleeping.
- The risk assessment did not state why Fluoxetine was being prescribed, did not highlight any risks associated with it or any specific side effects. The same risk assessment contained conflicting information. One part of the form stated 'allergy to medicines were unknown' where elsewhere on the document it highlighted an allergy to nine different medicines. This meant staff would not know about, or could become confused, around the risks to people from their medicines.
- Monthly medicine audits were being completed. These looked at whether people had mental capacity to make decisions, whether their health inhibited their ability to take medicines and also whether there were any potential hazards around storage or supply of medicines. However, it was not clear how medicine administration was being audited.
- We requested documentation to show how medicine administration was being audited and we were told that medicine administration was checked as part of the service's spot checks. Spot checks contained an element to state whether there were records of medicines taken, however, this lacked detail around medicines and what the service should be checking against when quality assuring medicine administration. Also, the service was unable to show us what exactly was being audited.

The provider had not ensured the proper and safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for Safe Care and Treatment.

During and after the inspection we shared our concerns with the provider. When we highlighted errors with the risk assessments, they updated them. The provider told us they would take our feedback into consideration and act accordingly.

● Medicine errors were discussed at meetings and staff advised about the importance of administering medicines as prescribed and record administration appropriately. People and relatives told us for the most part they managed their own medicines, which was confirmed by the service who stated the majority of people they worked with did not have their medicines administered by staff of the service. However, where medicine was administered by staff, this was viewed positively by people and relatives. One relative said, "[Family member's] medication is in blister packs, they like them [staff] to give them [medicines] to them [family member], then they're confident they've had them."

Assessing risk, safety monitoring and management

● Risks assessments were not always completed correctly. The service used a number of different risk assessments with people focusing on different aspects of care. These included but were not limited to medicines, mental health vulnerability and falls and mobility.

● Some risk assessments we saw lacked relevant information or contained contradictory information. For example, one risk assessment we saw stated a person had 'no history of fits or seizures' nor a history of falls. This was contradicted by their care plan which cited a diagnosis of epilepsy and provided information how to support the person when they had a seizure. Similarly, the care plan stated there was a recent history of falls and medicines used present a risk to increased falls. This meant care staff could become confused providing care to people as information in their care plans was incorrect in places.

● We shared our concerns with the provider, and they told us with respect to this risk assessment that some documentation required updating following a care review by the care commissioners and that it would be done imminently by the service. They also told us they would take our feedback into consideration.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● There were systems in place to ensure people were safeguarded from abuse. Staff were trained to identify and report the signs of abuse and the provider ensured local authority safeguarding were informed where there was the potential for or allegations of abuse. One staff member told us safeguarding was to, "make sure the client is safe, if not speak to the managers". People and relatives told us they felt safe with care workers. Their comments included, "We do feel safe with them, they always do what they can to help us."

● Lessons were learned when things went wrong. Incidents and accidents were recorded, and actions completed to ensure people were safe, or were referred onto other services to improve their health or wellbeing. Incidents and accidents were discussed with staff at team meetings or in supervision.

● We found one instance where an incident had occurred during a spot check. This had not been recorded as an incident and therefore no learning could be sought from it. However, staff at the time had ensured emergency services had been contacted to support with a person's health. We were informed this omission was an administrative oversight. Similarly, CQC were not always notified when safeguarding alerts were raised with local authorities, which the provider is required to do. They told us this was another administrative oversight.

Staffing and recruitment

● Call time punctuality required improvement. People and relatives had mixed views about staffing and their timeliness. One person said, "They are tight on time and sometimes rush us. They don't always make up the time if they're late arriving." Another said, "The managers had to come out once because they were so short staffed." Whilst another said, "They care and support us without seeming to be rushed."

● There were systems in place to ensure calls to people were completed. Staff used a phone app to log when they completed calls with people. Call monitoring data we reviewed indicated there was little issue with time management and sufficient staff to meet people's needs. Staff told us, "There is more than enough staff, if one isn't available, we always find someone to do the call or help out."

● Recruitment practices were robust. The provider completed checks on prospective employees to ensure

they were safe to work with people. These checks included seeking references, checking people's criminal record and checking their identity.

Preventing and controlling infection

● There were Infection control prevention measures in place to keep people and staff safe. Staff received training in infection prevention and control. The service held up to date information and guidance about infection control and specifically about COVID-19. Infection control audits were completed by management to support infection prevention measures. There was sufficient stock of Personal Protective Equipment (PPE). Staff were being tested regularly to minimise risk of COVID-19 transmission. A person told us, "They always wear their gloves, masks and aprons. They put them in my bin when they've finished." A staff member said, "We've had Covid training. Wash your hands, wear PPE; gloves, hand sanitisers."

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The service had failed to notify CQC about allegations of abuse when they had raised alerts with safeguarding teams at local authorities and also when the police had been called. Providers are required by law to notify CQC without delay when these types of incidents occur. It was clear from the service's systems that they had decided not to notify us when they should have, which highlights they were unclear about their regulatory requirements. When asked about this they stated it was administrative oversight.
- We found shortfalls at the service which required improvement. Medicine administration auditing at the service was minimal and records of what had been audited were not routinely kept by the service. Documentation at the service, such as risk assessments, lacked information. We also found one incident which had not been recorded correctly.

We found no evidence that people had been harmed, however, the provider had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There were a range of quality assurance measures in place. These included audits and spot checks. Audits we saw included infection control, care notes and medication audits. Spot checks were completed regularly and checked staff presentation and competence and provided an opportunity to gather feedback from people. The feedback we saw was positive and included compliments such as , "[person] loves the carers and is happy with them."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The service could improve on their communication with people and relatives. People and relatives had mixed views on staff and management. One person said, "I think management could do better. They don't seem to care, they don't get in touch to see how you are."

Whilst a relative said, "It is well run, they're easy to get hold of." A common theme when we spoke with people focused on communication from the service and also staff not having enough time to fulfil their roles in a person-centred way. However, generally people were positive about care staff. One person said, "One [staff member] in particular is marvellous, they go the extra mile, the rest are good."

● The service provided a service user guide which informed people what to expect from the service and how they should be supported. Care plans sought to gather information about people so staff would have an understanding of what people's needs were and what they liked.
● Staff told us there was a positive working culture at the service and management were supportive. One staff member said, "[The registered manager] is fantastic and [deputy manager] is too."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● Records of accidents and incidents indicated the service were honest with people when things went wrong. People and relatives were usually contacted shortly after a concern was raised and people were supported to access health care if required. However, we heard from one relative that this did not always happen. They said, "There was one occasion when [person] was poorly and they [staff] didn't let me know." Though they felt communication in their situation had improved.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
●The service could improve their engagement with people and relatives. People and relatives told us their feedback was sought from the service. However, not everyone felt positive about this engagement. One person said, "I think I need to give management a ring because I need better communication from them." Another said, "I told them on the form they sent that the [staff] need more time, I've not heard anything back from them yet. The form wasn't designed very well to answer it." The service provided quality questionnaires to gather feedback and also sought people's opinions when completing spot checks. Management told us that if they were informed about any issues, they would seek to address them.
● Staff were able to engage with the service through regular supervision and staff meetings. Supervisions provided the opportunity for staff to discuss matters they wanted in a one to one setting whilst team meetings offered the opportunity to do this in a group setting. Meeting topics of discussion included, but were not limited to, staff and client wellbeing, infection control and safeguarding.

Working in partnership with others
● The provider worked with others to support people and their care. There was communication and interaction with local authority social services and health care providers recorded on the service's systems. Commissioning partners we spoke to were positive about the service. One person who worked for a local authority told us they found the service to be, "be pragmatic and responsive."

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 HSCA RA Regulations 2014 Safe care and treatment Medicines were not being managed safely.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance measures were not robust.