Better Lives (UK) Ltd

Bluebird Care (Huntingdonshire)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Bluebird Care (Huntingdonshire) is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults, younger adults, people living with dementia and people with a sensory impairment. Not everyone using Bluebird Care (Huntingdonshire) received a regulated activity; Care Quality Commission (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.

Bluebird Care (Huntingdonshire) provided the regulated activity of personal care from an office based on the outskirts of Huntingdon. At the time of this inspection there were 22 people using the service.

The inspection took place on 12 January 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

This is the first inspection of this service under its current registration.

A registered manager was in post. 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.

Staff knew what keeping people safe meant as well as how to achieve this by managing any identified risk. Staff were trained in safeguarding people and were informed about who they could report any incident of harm to. However, we found that not all incidents of harm had been reported to the local safeguarding authority.

People were given information in a format that they could understand about staying safe.

Robust checks were in place to check that staff were only employed once they had been safe and suitable to care for people using the service.

People's needs were met by staff who were trained appropriately for their role and they were deployed to ensure people's needs were met.

People were not always administered their prescribed medicines safely. Advice had however been sought from healthcare professionals to ensure people's safety. Staff were trained and deemed competent to administer people's medicines by staff who had the skills to do this.

Staff were supported in their role and they knew what standard of care was expected. Incidents were used

as an opportunity for learning and to help drive improvements.

People were enabled to access healthcare services. People's nutritional needs were met by staff who knew each person's needs well. Staff knew when people needed support and also when to respect people's independence.

The equipment that staff supported people with was regularly checked to make sure that it was safe.

A positive and good working relationship existed between the registered manager, staff and relevant stakeholders. People were supported in partnership with other organisations including healthcare professionals to help provide joined up care.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were involved in their care and relatives or friends helped provide information, which contributed to people's independent living skills.

People's care plans contained sufficient information about the person to assist staff with providing person centred care. Staff understood how to provide care that was compassionate as well as promoting people's independence.

People were provided with information about, and or enabled to access, advocacy services when required.

Complaints were investigated in line with the provider's policies and procedures. Complaints were acted upon before they became a complaint.

Support arrangements and procedures were in place to understand and meet the needs of people requiring end of life care when this was required.

The registered manager motivated the staff team with regular meetings, formal supervision, mentoring and being shadowed by experienced staff.

The registered manager and provider had not always notified the CQC about events that, by law, they were required to do so. Audits were not always as effective as they should have been.

An open and honest staff team culture had been established by the registered manager and this meant incidents were reported where they needed to be.

We found one breach of the Care Quality Commission (Registration Regulations) 2009. You can see what action we told the provider to take at the back of the full version of the report.

Further information is in the detailed findings below.

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.

People were supported to stay as safe as practicable by staff who would recognise and report any such incident when it occurred.

Staff were subjected to a series of checks before they were offered employment.

Not all incidents involving people's safety had been referred to the local safeguarding authority.

Is the service effective?

Good

The service was effective.

People received care from staff who had undertaken the required training for their role.

People were supported to eat and drink sufficiently by staff who knew their needs well.

People were enabled to access healthcare support when this was required.

Is the service caring?

Good

The service was caring.

People were cared for and supported by staff in a dignified, compassionate and respectful manner.

People were supported to express their views and played an active role in determining what level of independence they had.

Care records were held securely and this protected people's confidentiality.

Is the service responsive?

Good

The service was responsive.

People were able to be as independent as they wanted to be and to be supported by staff as much or as little as they preferred.

People's concerns were effectively acted upon before they became a complaint.

Systems were in place to support people when required to have a dignified death.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Not all accidents and incidents had been reported without delay. This limited the CQC's ability to refer these to the appropriate authorities.

The registered manager fostered an open and honest staff culture and staff received the support they needed for their role.

A range of means was provided for people to give their feedback about the quality of service and their care.

Most audits were effective but the scope of these limited the provider's ability to improve when things had not always gone as well as expected.

Bluebird Care (Huntingdonshire)

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 checked 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 undertaken by one inspector and took place on 12 January 2017, and was announced.

We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

We visited the office location on the 12 January 2018 to see the manager and office staff; and to review care records and policies and procedures. We also contacted people and their relatives by telephone.

The inspection was informed by feedback from questionnaires completed by seven people using the service. This pointed out some concerns about care call times and duration and led the inspection team to explore this concern. The questionnaires also confirmed that people received good quality and safe care.

Before the inspection the provider completed a Provider Information Return (PIR). This is information we require providers to send us at least annually. This provides us with information about the service, what the service does well and improvements they plan to make. We used this information to assist us with the planning of this inspection. We also looked at other information we hold about the service. This included information from notifications the provider sent to us. A notification is information about important events, which the provider is required to send to us by law, such as serious injuries.

Prior to our inspection we contacted organisations to ask them about their views of the service. These were the local safeguarding authority and commissioners of the service. These organisations' views helped us to

plan our inspection.

As part of our inspection site visit we spoke with three people and three relatives by telephone. At the agency's office we also spoke with the registered manager, a supervisor and three care staff.

We looked at four people's care plans, staff training and supervision records and four people's medicines administration records. We looked at quality assurance and audit records in relation to, the management of medicines, care plans and people's feedback about the service. We also looked at two staff recruitment files, people's daily care handover records, accident and incidents and staff training and supervision planning records.

Requires Improvement

Is the service safe?

Our findings

Staff adhered to the provider's policies to help ensure that people were not subject to bullying, harassment or harm. Staff were trained in how to keep people as safe as practicable and they were knowledgeable about how to put this training into practice. Staff empowered people to be safe and they were able to describe the signs and symptoms of any potential harm. One person told us, "I feel safe as they [staff] are very punctual; they stay with me until all my [care] has been completed." A relative said, "Having the same consistent staff was one of the conditions in us choosing [the provider]. We have never been let down. This means a lot to my [family member]."

We saw in the service user guide people had been given information that included the types of potential harm and how to report this if necessary. This also included what the person wanted to happen such as a change in their care staff before any incidents occurred. Where personality clashes had developed staff had been changed and people remained satisfied that they were as safe as they could be.

Appropriate risk assessments were in place to help support and promote people's safety. Examples of these risk assessments were for people's medicines' administration, their home environment and the recruitment of staff. We saw that these records of people's risks were up-to-date, accurate and that staff followed any guidance such as that from a community nurse. This was to help keep people as safe as practicable with their skin integrity.

We found that staff had been recruited in a safe way and that there was sufficient staff to meet people's assessed needs at a time that they preferred. One relative told us, "If staff are running late we always get a phone call from the office staff. In emergencies such as road closures, we can manage but someone [staff] will get to us when they can. It's never an issue." Checks were in place for the safe recruitment of staff. These included a Disclosure and Barring Service (DBS) check for any criminal records, which could prevent staff from being employed. One staff member said, "I had to bring in my passport, two written references and my employment history. I also had to evidence my qualifications. I didn't start until my DBS came back clear."

People told us that staff who had the right skills were deployed in a way that promoted people's safety such as by using people's moving and handling equipment in a safe way. The registered manager and staff were also skilled at sharing information about people's care with other stakeholders such as the community nurse. This was for where this was needed for people's safety. For instance, for people with pressure ulcer care needs such as repositioning and dressing changes. People's safety was also promoted by being enabled to access organisations that supplied equipment such as aids for mobility, eating and drinking and those for safe bathing and washing.

People's safety was promoted as a result of staff's understanding of safe systems of work. These included training on subjects including moving and handling, infection prevention and control. And how to turn off any utility power supplies in an emergency. Staff wore protective clothing during people's care and food preparation and this helped to provide people's care as hygienically as possible. This was in addition to infection prevention training and hand wash techniques.

Staff had been trained in how to safely administer medicines as well as having their skills at doing this assessed to make sure they were safe. Where errors had occurred such as missed medicines or people being administered the wrong dosage, actions had been taken. This was to reduce the risk of reoccurrence. This included reminding staff of their responsibilities to correctly record administered medicines only as prescribed and contacting out of hours healthcare services. Although staff had reported these incidents correctly, we found that the registered manager had not reported this to the local safeguarding authority. They told us, "I didn't realise that this was a safeguarding incident." This meant that lessons could not be effectively learned when things had not gone well.

The registered manager told us they would always report any future safeguarding incidents without delay. When things had not always gone as planned, the records for any potential trends in incidents had not recognised this situation. This limited those organisations responsible for investigating safeguarding in being able to offer any potential advice and guidance to keep people safe.

Good

Is the service effective?

Our findings

People's care and support needs were assessed to help determine how these needs would best be met. Examples of needs which had been determined included those for washing, dressing, medicines administration, moving and handling and health conditions which staff needed to be aware of. This was as well as any equipment which people had been determined as having a need for. People's needs were supported by staff who treated people equally and no matter how complex each person's needs were.

To meet the needs that people had, staff were supported to have the right skills and to use equipment safely. Staff were enabled to have these skills with training on subjects such as health and safety, food hygiene, equality and diversity, and the Mental Capacity Act 2005 (MCA). The person said, "They [staff] know me ever so well. I rarely have to tell them [about the care] unless it is a new one [staff] who is learning with the more experienced ones." One relative told us, "The staff couldn't be any better. I can relax knowing my [family member] is getting the care they need and in a way which helps them live at home."

Staff received additional support through regular supervision, mentoring as well as observations of their care practice. These support mechanisms helped ensure that staff's skills remained current and relevant to people they cared for. One staff member told us, "I have regular supervision every few months. It is an opportunity to say what is going well and also to ask for any additional training or guidance. I can ask at any time and I don't have to wait."

People were supported with their nutritional needs by staff who knew what people's food and drink preferences were. One person said, "I get all my favourite foods such as shepherd's pie and sponge puddings. I am always left a hot or cold drink within reach." Staff told us they promoted people's choices by prompting them with a selection of meal and drink options. The time of staff care calls was to coincide with the times people chose to eat. Where required, staff monitored people's daily food and drink intake to ensure they had sufficient quantities as well as a diet that was appropriate such as one low in sugar.

When people either started using the service or they returned after a period in hospital with a change in their care needs, staff were made aware of these changes. This also included being aware of whom to liaise with in meeting the person's latest care needs. For instance, a GP or community nurse. Any changes to people's care which involved other stakeholders was included in people's care plans and staff were made aware of these.

People were enabled to access external healthcare support for example, from an occupational therapist or GP. Staff also accompanied people to healthcare appointments where this was required. One person said, "I am sure they [staff] would call a doctor for me if they felt I was unwell." A relative told us, "I can deal with all health aspects of my [family member's] care. However, if I am out I wouldn't have any worries that staff wouldn't hesitate to call an ambulance or GP." Reviews of people's care plans enabled people to be involved in determining any healthcare support that may be required.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be

deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this community care services are applied to and authorised by the Court of Protection. Nobody using the service had a need to be deprived of their liberty to keep them safe. The registered manager was aware of the process to contact the person's social worker or legal representative if people had been determined as lacking mental capacity. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

One person told us, "The girls [staff] give me time to choose what I want to eat. If I forget something they [staff] help me to choose. I can change my mind if I want and they [staff] respect this." Staff had a good understanding of the MCA and its code of practice. People told us that staff supported them to make informed choices such as offering a selection of clothes. This was as well as prompting people to take their medicines. One staff member said, "I always assume that people can make a choice. I don't rush them. I would let the [registered] manager know if people were struggling with their decision making." People could be confident that their choices would be respected and any care that was provided in a person's best interests would be lawfully agreed.

Good

Is the service caring?

Our findings

People were well cared for by staff who understood what treating people equally meant. For example, no matter what any person's needs every person was treated equally. One person told us, "I was able to provide lots of information about my care when I first started with them [provider]. I feel it reflects my needs well and they [staff] treat me just as I like to be, carefully." A relative said, "They [staff] are approachable, caring and interested in me and my [family member]."

All of the people and relatives we spoke with and responses to our survey questionnaire confirmed that care was provided in a dignified, sensitive and compassionate. One person we spoke with said, "The staff are always friendly and willing to help me and encourage me if I am feeling unwell or low." Another person told us, "They [staff] are ever so kind. It doesn't matter what I ask they are polite and do everything I need. We have a good old chat too and a laugh." Staff described to us the circumstances they needed to be mindful of to protect people's dignity and promote person centred and compassionate care. For instance, by making sure that curtains were closed and allowing people to be as independent whilst doing their own personal care.

We found that people with religious beliefs and values were supported to take part in these, such as going to church. This helped people to practice their beliefs.

People's care plans included sufficient detail and guidance for staff to provide people's care in an individualised way. One staff member said, "The care plans are quite clear."

Records showed us where people were supported with advocacy, such as from a relative who had authority to act on their family member's behalf. Information in the provider's policies and guidance from the registered manager also supported people to promote their views. People were provided with information about, and or enabled to access, advocacy services when required.

We found that people's care needs were acted upon promptly and in a dignified and respectful manner. This was because staff were rostered in a way which gave them the time to meet people's care needs in a compassionate way. For example, by having the time they needed to be able to care for people during the care visit. People and relatives we spoke with confirmed that staff always ensured that any necessary pain relief was provided. Staff also made sure that before they left a person's house that they were as comfortable as possible. One person told us, "The girls [staff] couldn't do any more for me to make sure I am well looked after."

People's care records were regularly reviewed to make sure they accurately reflected people's personal care needs. Where people's confidentiality was to be respected we found that staff adhered to this requirement. For instance, by keeping records in a secure place and only involving those people and relatives where this was necessary. One staff member told us, "The training we do is at a time when we can do it such as at home. It does not affect the time we have to care for people."

Good

Is the service responsive?

Our findings

People were able to be as independent as they wanted to be and to be supported by staff as much or as little as they preferred. The care and support that people needed was determined after an assessment of their needs had been completed. This allowed people, or those acting on their behalf, to have a say in how and when their care was provided.

We saw that care plans were up-to-date and an accurate reflection of people's needs including information about the person's life history. This allowed staff to engage in conversations that the person could take an active part in and by staff who had been matched to the person's interests. For example, interests in TV, sport or gardening.

Various systems were in place to support people's social stimulation during care calls as well as visits by relatives and friends. Other ways that people were assisted to have regular pastimes and interests were by staff reading magazines that people liked and supporting people in an individual way, such as with knitting.

We found and people told us that they had systems to support their wellbeing such as an emergency life line call system. One person told us, "I need to wear my life-line and they [staff] make sure I do in case I need emergency care." In addition, staff had mobile phones where they could contact the registered manager if any person's needs had changed such as those to care call times or their duration.

People's concerns were effectively acted upon before they became a complaint. One person told us, "If I ring the office they [staff] sort out my issues. I never complain as I get such a quick response. If I need the days of my care changing I just ask and it's done." The complaints' policy included guidance about any support a person may need such as advocacy. And anyone else they could contact. For example, the Local Government and Social Care Ombudsman. This gave people additional assurance if there was a need to investigate the provider's complaints process.

At the time of our inspection no person was in need of end of life care. We did however, find that systems were in place to support people when required to have a dignified death. These systems included arrangements to assist families with the grieving process. This was in addition to having arrangements for people's advanced decisions for any emergency treatment or resuscitation.

Where required, we saw that people with a lasting power of attorney had contributed towards these end of life care decisions. People could be confident that their wishes would be respected. One staff member told us, "It is always a sad time when a person passes away. I would know when to ask for support and involve [registered manager] or a community nurse." People could be confident that their wishes would be respected.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in post and had been so since the service was registered in December 2016. We found from records viewed that the registered manager and provider had not notified us about events that, by law, they are required to do so without delay. This was for three separate incidents which had occurred as far back as May 2017. Our records confirmed that no notifications had been submitted to the CQC since the service was registered. We asked the registered manager to notify us about these incidents, which had occurred in 2017. They told us on the notification about a grade four pressure sore, "I was not aware I had to report pressure sores to the CQC." This was also against the provider's policies for reporting incidents of harm. This showed us that the registered manager was not aware of their full range of responsibilities and prevented the service from being as good as it could have been. This meant that those organisations responsible for safeguarding people were not kept informed as well as the CQC not being aware of the trends that had developed.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager had fostered and maintained an open an honest staff team culture where incidents were reported to them. One relative told us, "They [office staff] are very good at getting back to me. I am confident they deal with any concerns openly." A range of support mechanisms were in place for staff including regular supervisions and one to one meetings. There had however, only been one staff meeting recorded in 2017 which limited the gathering and sharing of information about the whole service. The registered manager had regular contact with a representative of the provider to keep them up-to-date with information and guidance about developments in social care. This was also an opportunity where they could share their concerns and request any additional support for any challenges such as recruiting staff with the right skills.

The registered manager told us that they did have monitoring arrangements in place, such as spot checks as well as observing staff's care practice. They went on to tell us that any feedback could then be given in private but having more meetings was an area they wished to develop. A staff member said, "If I need support I just need to ask for it. [Registered manager] or a supervisor is always on call and we can contact them at any time we need to. I had a spot check last week which went well."

Staff told us that they were made aware during one to one meetings as well as spot checks of what was expected from them. One relative told us, "The girls are very consistent in meeting [family member's] care. They are all very good. I would recommend them to anyone." We found that staff were held accountable for any decisions they made, such as where medication errors had occurred.

A range of checks, audits and governance procedures were in place. However, these were not always as effective as they should have been. Where we had not been sent notifications about incidents the registered manager's and provider's audits had not identified this omission. Other audits for medicines records and incident records showed us where actions had been taken and that these had been effective in driving improvements.

People's and staff member's views about the service were entirely positive. One person said, "I know [registered manager], she is very helpful and sometimes checks on the [staff]."People were offered various opportunities to contribute to how the service was run such as an annual quality assurance survey. This was as well as contacting the office staff and care staff during daily care calls. Where people had a relative or legal representative they could also provide information to help make any necessary improvements if these were needed. The registered manager also spent time caring for people and we found they knew each person individually.

Staff told us that they could raise any concerns if ever they had these about any poor quality care. One staff said, "I know I would be supported by [registered manager]. I am also confident that changes would be made and any staff who were not up to scratch wouldn't be working here." Compliments we looked at showed us what the service did well. One example of these was, "Thank you to [registered manager] and your team for being so good to [family member]. All the [staff] are very good."

Staff were made aware of their care call rosters by mobile phone as well as regular contact with the office supervisors. There was also an electronic communications system, which informed staff immediately about any changes. This messaging system was set up to deliver information to staff at an acceptable time of day. The registered manager told us that electronic care call monitoring was being considered, especially as the business grew.

Records and people we spoke with confirmed that the service and its staff team worked well with other stakeholders, such as the community nursing team. One person told us, "I have different types of care and it all seems to work well." A relative said, "My [family member] needs care and nursing but at home. I have never had any issues as the [staff] always let me know of any changes. I would whole heartedly recommend this service."

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 18 Registration Regulations 2009 Notifications of other incidents Statutory notifications had not been sent to the CQC to inform us of serious events, which the service is required to do.