Aquahigh Limited

Bluebird Care (Merton)

Inspection report

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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?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This announced inspection took place on 22 and 28 August 2018.
At our last inspection of 17 December 2015, the service was rated 'Good' across all domains.

Bluebird Care Merton is a domiciliary care agency. 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.

Not everyone using Bluebird Care Merton 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 the time of our inspection 57 people were receiving care.

At the time of our inspection the director was awaiting interview for their CQC registration as 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.

At this inspection we found that the provider was in breach of the regulations relating to good governance. You can see the action we have told the provider to take about these breaches at the back of the full version of this report.

We found that developments were needed to ensure quality assurance systems were appropriately managed and improvements to the service made in a timely manner. Audits conducted of incidents and complaints were not effective in identifying patterns and trends. Care plans for people using the service were not always regularly reviewed. Feedback from people and relative satisfaction surveys was not analysed to support improvements across the service. People were not always supported to express their wishes in relation to end of life care preferences.

People and their relatives were not always satisfied with staff attending their calls on time, and expressed concerns with how office staff communicated with them. The director had highlighted this as an area for development and had focused on office team development through team meetings and supervisions.

People were supported by staff that knew how to safeguard them, and appropriate checks had been carried out to ensure staff were safe to work with people. Staff were aware of their responsibilities in relation to infection prevention and control. Incidents and accidents were appropriately investigated as and when they occurred. People's risk assessments and administration of medicines were comprehensively assessed and managed to ensure that people received the support they required.

Staff received regular supervision and appraisal to support them in their roles. People were supported to eat

balanced meals of their choice. Where people needed to access healthcare professionals the service supported them to do so. People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice. Staff sought people's consent when delivering care. People's needs were assessed in line with best practice guidance.

People felt that staff were caring and attentive to their needs. People's privacy and dignity was respected, and staff were considerate of people's needs when supporting with personal care. People's care plans, and staff support reflected that people were supported to be as independent in tasks as possible.

People's care plans were comprehensive in detailing people's preferences in how they wanted their care needs to be met. Complaints were appropriately investigated and responded to in a timely manner.

Staff recognised that the director had made improvements to communications between staff in the field and in the office. A new quality and training manager had been recruited to focus on improvements in these areas. The director was aware of their responsibilities to the CQC and worked to develop positive relationships with partnership agencies. The director had a vision to expand the business and was focused in improving the current customer service provision.

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 commented on improvements made by the office in the communication of late calls.
Recruitment checks ensured that staff were safe to work with people, and staff were aware of how to manage infection control.
Incidents and accidents were appropriately managed, and people's risk assessments were robust in managing potential risks.

Is the service effective?

Good

The service was effective.
The provider ensured steps were taken to ensure gaps in staff training were rectified.
People were supported to access healthcare professionals, and maintain a balanced diet of foods of their choice. People's consent was sought when delivering care.

Is the service caring?

Good

People were cared for by staff that respected their privacy and dignity.
People were supported with any religious or cultural needs.
Staff knew people they cared for well and supported them to be as independent as possible.

Is the service responsive?

Good

The service was responsive.
The provider was in the process of reviewing care plans that they identified required updating. On the second day of inspection, the provider took action to implement end of life care plans for people.
People's care plans were clear in detailing people's preferences in how they wanted their care to be delivered.
Complaints were managed appropriately.

Is the service well-led?

Requires Improvement

The service was not as well-led as it could be.
The director had not ensured that quality assurance audits were always effective in identifying trends and driving improvements.

Plans were in place to develop links with other community organisations.
The director had identified improvements in communication were needed across the service. Staff felt well supported by management.

Bluebird Care (Merton)

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.

This inspection took place on 22 and 28 August 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 inspection was conducted by one inspector and an expert-by-experience who made calls to people and their relatives to seek their views of the service. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was in supporting older people with dementia.

Prior to the inspection we reviewed information we held about the service. This included notifications the provider is required by law to send us about events that happen within the service.

On the first day of inspection, we spoke with the co-ordinator, a supervisor, the quality and training manager and three members of staff. On the second day we spoke with the director. We looked at the care records for four people using the service, as well as looking at a range of documents relating to the service including daily records, incident and complaints records and quality assurance audits. We also looked at four staff files.

During the inspection we attempted to contact 13 people or their relatives. We were successful in obtaining feedback from four people and five relatives.

Good

Is the service safe?

Our findings

People and their relatives told us that they felt the service was safe, and that they were treated well. One person said, "They treat us very well…They are good and kind and take time with him [relative]; sometimes he's [relative] slow." A relative told us, "Oh yes they do [treat his mother well]."

We received mixed views on whether staff attended calls on time, and that office staff were not consistent in communicating lateness to people. Comments included, ""If they're running late they [staff] phone the agency; they're too busy to let me know", "No they're not on time – always about 10 to 15 minutes late but the service has improved recently [in the last few days] – they've been phoning to say so. They've been consistently late since Christmas and they're late in the evenings", "Umm, it varies. Occasionally [they're late]" and "The office can't organise carers to get from job to job. They're losing a lot of carers."

Positive comments included, "Mostly [on time] but sometimes they're a bit late but they do call to let me know", "They are on time. I'm very strict on them about that. I get on very well with them" and "They're mostly on time. I take everything into consideration like traffic." We spoke with the director about the feedback we received in relation to lateness at attending calls. The director had a new co-ordinator in post, and also had a trainee co-ordinator that was currently working as a care worker. An electronic call monitoring system was in place that immediately highlighted any lateness of calls. We looked at the call records for the previous week and saw that office staff had been prompt in managing any instances where staff were running late to calls. A staff member told us, "Times between calls has gotten better, there's more understanding about our travelling. They'll [office staff] let people know if we are running late, they're given a realistic time. Things are improving." The director told us that improvements in office communication had been identified, and that this was a current area of focus. Most of the people, relatives and staff that we spoke with felt that lateness of calls was improving. We will check on the provider's progress in office communications at our next inspection.

There was sufficient numbers of staff scheduled to meet people's needs. Where people required two people to meet their care needs this was appropriately scheduled, and staff rota's showed that enough time was scheduled between calls.

People had comprehensive risk assessments on file that covered a range of topics. Areas included internal and external environmental risks, medicines, moving and handling and falls. Where one person was at risk of falls, records showed that their risk assessment was reviewed each time a fall occurred. People's care plans included clear overviews of people's medical history so that staff could be clear on the support they required to manage any risks around these areas. For example, one person's risk assessment detailed how they required support to manage their finances appropriately. Staff were clear on how to manage specific risks to people. One staff member told us of a person they supported with epilepsy and how they spoke to their relative to ascertain their symptoms when at risk of a seizure.

People's medicines requirements were well managed and care plans were particularly detailed in providing support guidance for staff. Each person's care plan included a list of people's medicines, what they were for,

all possible side effects and the dosage people required. We looked at medicines administration records (MAR) for three people using the service and saw that any gaps in the MAR were explained and staff detailed medicines they had administered in the daily care notes. Staff that we spoke with were knowledgeable about the medicines administration process telling us, "I let the person know it's medication time, I ask if I have permission to do that. I do all the checks – name on the blister pack, dosage on the system including the colour and tablet shape. I administer into the pot and watch [the person take the medicine]." The provider had a medicines policy in place that provided guidance for staff on administering and recording people's medicines.

People were appropriately safeguarded from the potential risk of abuse. Records showed that the director had taken sufficient action to ensure that any safeguarding issues were investigated and advice sought from the local authority safeguarding teams. Staff knew the action to take if they suspected that someone was at risk of abuse telling us, "For example, financial, emotional, physical [types of abuse]. I would call the office, if I'm not happy with the office I would call the on-call. I'd tell the CQC or the council." Records showed that any safeguarding incidents had been promptly reported and appropriate action taken to investigate them.

People were supported by staff that had been assessed as suitable to work with them. Staff files included two suitable references, history of employment and proof of identity. Staff were subject to disclosure and barring (DBS) checks prior to commencing work with people. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Staff received training in relation to the prevention and control of infection. People told us they felt staff were well trained telling us, "I've noticed that they are very particular about keeping good hygiene [practices]" and "Oh yes, they must be trained for that [good hygiene practices]. They use gloves and wipe up drips." Staff told us they received appropriate training to support them to conduct their role in line with infection control guidelines. One staff member told us, "I ask to wash my hands, use shoe protectors at the door, apron goes on and gloves. I use face masks if it's necessary."

The provider had a process in place for recording and investigating any accidents or incidents as they occurred. Concerns were recorded, including any witness statements and the action taken. We looked at past team meeting minutes and saw that a recent medicines error had been discussed, and staff were reminded of the procedure for highlighting any incidents of accidents. Staff that we spoke with knew of the need to communicate any concerns to the office, and write up any potential incidents.

Good

Is the service effective?

Our findings

Records showed that not all staff were up to date with the provider's mandatory training requirements. Staff were required to undertake training topics such as end of life care, safeguarding of vulnerable adults, moving and handling, mental capacity act, health and safety, food safety, dementia, mental health and basic life support. Staff told us that training was a mix of face to face training and a newly implemented e-learning package. One staff member told us, "It's been good, I've received all the training." We looked at the provider's training matrix and saw that some staff required refresher training to be undertaken. Following the inspection, the provider sent us an updated training matrix to show that all staff were up to date with mandatory requirements and had been booked on future additional training sessions.

Staff received regular supervision and appraisal to support them in their roles. A staff member told us, "I can come in whenever I want to have one [supervision], otherwise every two to three weeks. I can pop in if I need to clarify something, someone's always here." Another staff member said, "We discuss people [using the service], how I'm getting on." Records that we looked at showed that staff were up to date with the provider's supervision requirements.

People's needs and choices were assessed in line with best practice guidance. Where people had been identified as needing support with skin integrity their needs had been assessed against the waterlow score. People and their relatives felt that staff were knowledgeable in meeting their needs telling us, "Yes they know what to expect before they come here. I have every confidence in them knowing what to do" and "They're good at communication."

Staff utilised an electronic care management system to ensure that records of their daily interactions with people were clearly recorded. We saw that where potential issues were highlighted staff approached the office to ensure people's needs were met. For example, one staff member noted a sore on one person, compromising their skin integrity. The daily notes detailed the action staff had taken to discuss this with office staff, and we could see the action the office had taken to liaise with the tissue viability nurse, GP and pharmacy to ensure the person's needs were met.

People were supported to access healthcare professionals at times that they needed them. One person received live-in care and records showed that the GP was contacted when they became ill. One staff member also liaised with physiotherapy to ensure one person received the support they required. One staff member told us, "I know it's part of our duties to escort people to appointments. I've been before to the chemist, to collect medicines. I know we can talk to the hospital." People's care plans named key healthcare professionals for each person and appropriate contact details so that they were accessible to staff. People sought support from a range of professionals such as, speech therapists, chiropractors and district nurses.

People were supported to access a balanced diet, and meals of their choosing. One person said, "I have ready meals and my daughter cooks food for me and they just have to heat things up. Occasionally I'll ask them to cook a bit of white fish if I tell them what to do." People's care records reflected people's preferences in their food choices, and daily notes showed that these choices had been accommodated.

People's food and fluid intakes were clearly recorded on the electronic care management system. Staff knew how to support people to maintain regular food and fluids telling us, "I'll ask people what they want for dinner, make sure it's cooked properly, that they're sitting up properly. I would check my care plan or the folder [in person's home]."

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 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. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. When people are living in their own homes, this is done via the Court of Protection.

We checked whether the service was working within the principles of the MCA. People told us that staff sought their consent when caring for them saying, "Yes, they do [seek consent]" and "Yes they do. They always say things like, 'do you mind sitting while we do this and that?'…. and things like that." Staff members told us, "I always as, 'if that's ok with you?'" and "I'd ask them." Care plans were signed by people to confirm that people consented to the care package provided. Where it had been deemed that a person did not have capacity the provider ensured that a capacity assessment was completed and detailed why a person was unable to make decisions for themselves and other important professionals involved in their care.

Good

Is the service caring?

Our findings

People and their relatives spoke highly of the care they received from the service. Comments included, "They make him feel valued and respected and put his comfort first" and "Most of them are nice and chatty and they treat you like a person." Staff were passionate about their work and the people they supported telling us, "I'm friendly, I'm calm. They say I have a heart as big as a bucket. I like to go the extra mile" and "I'm person centred, I always ask them [people]."

Staff knew the people they cared for well. They were able to relay to us people's likes and dislikes, family histories and the ways in which people liked to be cared for and spoken with. People's care plans also included details of people's histories covering details such as previous employment, family networks and what is important to them. These were often included in the summary of people's care plans meaning they were easily accessible to staff.

Staff understood that people's presenting needs needed to be met with sensitivity and knew how to communicate with people effectively. One staff member said, "I sit down if they are, or I kneel to be on their level. I explain things to them, and I go back to it. For example, I'll show people their name on their medicines to assure them that they are theirs." Another person's care plan detailed that they needed to be spoken to slowly by staff as they found it difficult to communicate.

People were supported with any needs that reflected their religious or cultural preferences. One staff member told us how one person liked to pray before they bathed and that they respected this.

People's privacy and dignity were respected. People and relatives told us, "Yes they do [treat me with dignity and respect]. They help to wash me but I can do my own bits", They have to do intimate things like help her with her pants and [relative] screams quite randomly. You've got to keep talking to her with a positive energy and they do that." Staff members told us, "You have to respect what they [people] do and don't like, it's about them as an individual" and "[When delivering personal care] The door should be closed, a sheet to be put over them. The curtains are always closed."

People were supported to be independent in care tasks that they were able to carry out for themselves. Relatives told us, "She's [relative] 96 but she can brush her own teeth and they encourage her to do that. They are patient with her and yes, they do give her time to do things" and "They tell him [relative] that it's good to walk and encourage him to do what he can for himself." One staff member told us, "I talk to them [people] and find out what they like doing. One lady likes cooking so I make simple dishes with her. I wait and eat with her to encourage mealtimes."

Staff knew the importance of confidentiality telling us, "Don't talk about it [care] outside of the room. When there, in the moment, it's all about the person. I keep questions about my private life brief."

Good

Is the service responsive?

Our findings

People and their relatives told us that they were involved in the planning and review of their care. One person said, "They review [the care plan] once a year. The manager came recently to review and did the service at the same time." A relative said, ""Yes they [staff] come in their smart cars for reviews." On the first day of inspection we noted that not everyone using the service had been subject to an annual review in line with the provider's requirements. However, we did see good practice in that people's care needs were reviewed when their needs changed or when they were released from hospital for example. The provider had identified that eight people using the service were overdue a care plan review, they reviewed the person's level of risk and following inspection, sent us dates to show that people's review dates had been booked.

At the time of inspection, the service was not supporting anyone in receipt of end of life care, however people's care plans did not reflect that their end of life wishes had been discussed with them. By the second day of inspection the quality manager had compiled a template of questions to ask people, to ensure that they were provided with the opportunity to discuss their end of life preferences should they wish to do so. We will check on the provider's progress with this at our next inspection.

People received personalised care that was responsive to their needs. People's care files contained pre-assessment information that relayed the care people required. One person said, "Yes. They came here from the office and asked what I wanted them to do." Care plans that we reviewed were comprehensive in detailing people's care need preferences. Details included how people preferred to live their lives' and daily routine preferences. Where one person required support with moving and handling and their care plan detailed the sling to be used for hoisting, how to manoeuvre the person at each stage and how the person needed to be supported and encouraged whilst in use.

Each person's care plan detailed the outcomes they wished to achieve through being in receipt of the provider's care. We found that these were personalised in line with people's requirements, for example one person required staff to support them to keep their skin intact. Each care task delivered to a person was assigned to an outcome, so that that staff were clear on how their care duties supported people.

People and their relatives knew how to complain to the office if they wished to raise any issues, telling us, "I had to phone them about the poor timekeeping once and it's never happened again", "We complained once when she was dehydrated when we were away…they took it seriously" and "Yes I would [complain]." We reviewed the provider's complaints records and saw that the majority of complaints received had been in relation to missed or late visits. Some complaints were in relation to staff conduct and engagement with people using the service. We saw that the provider had investigated each complaint appropriately, and responded accordingly. Where one person had not been satisfied with their care worker, management had increased supervision of the care worker to ensure that conduct was regularly addressed.

Requires Improvement

Is the service well-led?

Our findings

We found that improvements were required to the provider's quality assurance system to ensure that feedback in relation to the service was reviewed in a timely manner. The provider had not ensured that people's care plans were always reviewed in line with the provider's policy. Audits were conducted of incidents, accidents, concerns and complaints; however, the nature of the incident was not always clear and the quality assurance audits completed were not used to identify and patterns and trends. The provider had not ensured that people were supported to express their end of life wishes if they wanted to do so. The provider had recently conducted a satisfaction survey with people and relatives, however the findings had not been collated to help drive improvement across the service.

We received mixed views from people and relatives in relation to the management of the service. Less positive comments were primarily in relation to the turnover of office staff and care workers including, "Not really [well-managed service], they don't follow through and there's a lack of consistency with the care staff" and "The Coordinator doesn't last more than 6 months – you just get to know them and then they go. I think that management over-stretch their staff to cover the calls. This impacts on staff; they ask too much of them especially on weekend visits. There's a whole range of issues I think that they ask one too many favours from staff to cover jobs."

More positive comments received included, "Yes, it is well-managed. The only thing is the timekeeping – will they keep it up?", "The manager visited 2 or 3 times to review things" and speaking of the supervisor, "She [supervisor] seemed very pleasant", "I haven't met them [manager] but I think she's [supervisor] very good."

Staff that we spoke with recognised that management and office staff support had improved. Comments included, "It's getting better, the office team at the moment is like the best we've ever had. They're learning [the office] to listen to us more, show more appreciation", "It's good, I've never had problems with anyone in the office. They've always been on the other end of the phone. I love my job, I love it" and "Yep, he's a good manager. He listens to you, nearly always has some answer or solution. He will always call you back. Everybody's nice, everybody's receptive to what you say."

These above issues are a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The above issues notwithstanding, we did note that the provider conducted regular audits of people's medicines and daily note records. Where issues were identified it was clear what action was required to support staff to make improvements.

A quality and training manager had also recently commenced employment at the service. The director told us that this was with a view to ensuring there was primary focus on improving quality assurance systems across the service, and ensuring that staff training remained up to date and relevant to people's needs. The director's vision was to ensure that compliance systems improved and that staff received engagement relevant to the people they cared for, for example aiming to work with the Alzheimer's society to improve

care for people with dementia. The director also told us of the need to grow and improve the customer service offered by the office team.
We saw some good examples of how the service had worked to improve people and staff satisfaction. For example, providing people and staff with birthday cakes and one person's milestone birthday resulting in an article in the local paper. Staff also received commendation through 'carer of the quarter' and a recent 'random act of kindness' had been implemented to demonstrate appreciation of staff commitment.

The director was aware of their responsibilities to the CQC, and submitted notifications about important events in a timely manner. Staff were invited to share their views through regular team meetings, and a suggestions box was accessible in the office.

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 17 HSCA RA Regulations 2014 Good governance The provider did not ensure that governance systems were effective in delivering improvements promptly. 17(1)(2)(a)