Faster than a Cat Ltd

Faster than a Cat t/a Bluebird Care (Trafford)

Inspection report

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Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

We inspected Faster than a Cat t/a Bluebird Care (Trafford), known to people who use the service as Bluebird Care (Trafford), on 31 May and 01 June 2016. The first day of the inspection was unannounced. At the last inspection in October 2013 we found the service met all the regulations we looked at.

Bluebird Care (Trafford) is a domiciliary care agency. This means that care workers travel to people's homes to support them according to their assessed needs. At the time of our inspection, 75 people in the Trafford area were being supported by the service in their homes with various aspects of their personal care.

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.

Overall the management of medicines by the service was good but we did find two issues. These were a medicine protocol that lacked detail and a medicine care plan that had not been updated when a person's medicine had changed. The service took action during the inspection to correct the issues.

Risks to people had been assessed and control measures were in place. However, we identified one person who was being supported by staff to use a hot water bottle and there was no risk assessment in place. The service planned to put a risk assessment in place as soon as possible.

People told us that care workers used personal protective equipment when assisting them with their personal care. We saw records which showed a care worker had persistently flouted the infection control policy; the service had identified the problem via spot checks and was in the process of addressing the issue with the care worker at the time of our inspection.

The service recruited new care workers safely. Care workers could describe how to protect the people from abuse and said they would report any concerns appropriately.

We saw improvements had been made to the visit scheduling system so that care workers arrived on time for their visits. People told us that care workers were rarely late, and when they were, it was almost always due to traffic problems which could not have been avoided.

People told us that care workers were well trained. Care workers told us and records showed that they had access to regular mandatory training as well as specialist courses to help them support people with complex conditions. In addition, care workers received regular supervision, on the job spot checks and an annual appraisal.

The service was compliant with the Mental Capacity Act 2005 and staff could tell us how the legislation

impacted upon the people they supported.

People received person-centred support to eat and drink when they needed it. The service also assisted people to maintain their holistic health according to each individual's needs and mental capacity.

People told us they had developed friendly relationships with the care workers, and that care workers respected their privacy and dignity. People also described how care workers supported them to remain independent.

The service provided people with information on advocacy and referred people to advocacy services if they needed it. We saw detailed, person-centred care plans of people who had received end of life from the service and feedback from their relatives which was highly complimentary.

The service tried hard to ensure it employed care workers with the right caring values and that people were supported by a small team of regular care workers.

The service was transitioning from paper records to an electronic care planning system. We saw that care plans of each type were detailed, individualised and person-centred. There was a system in place to ensure care workers could provide support even if there were technical difficulties accessing the electronic system.

People's care plans were flexible and reviewed with them regularly. Relatives and healthcare professionals could access the electronic system with the person's permission. Existing 'customers' that did not like the new electronic system could revert to paper records if they chose.

We saw that complaints were investigated, recorded and resolved according to the complaints policy. People and their relatives felt able to raise any issues or concerns with the care workers or staff working in the office.

The service was extremely committed to continuous improvement and had gone to great lengths to involve its staff, the people using the service and their relatives.

The managing director and registered manager were forward thinking and used innovative new technology to improve the service's responsiveness to the people using the service via audit, monitoring and quality assurance.

Care workers felt highly valued by the service. We saw the managers tried hard to involve care workers in developing and improving the service. Care provided was evidence-based and care workers were encouraged to celebrate and share their own good practice.

There was a refreshingly open culture at the service. Staff felt able to admit errors and received support to improve when they did. The managing director had developed a philosophy of care for the service and care workers could describe how the service's vision and values underpinned the support they gave to the people.

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.

The majority of medicines were managed well, although we did find some issues with documentation. The service corrected them during the inspection. Risks to people had been assessed; however, one person was supported with a hot water bottle which had not been risk assessed.

A care worker who had ignored the infection control policy was being managed by the service. People told us care workers used gloves and aprons when supporting them with personal care.

The service had a robust recruitment process and care workers could describe how to recognise and protect people from abuse.

Is the service effective?

Good

The service was effective.

Care workers told us and records showed that they were up to date with all the mandatory training subject areas. Care workers also had access to specialist training so that they could support people with complex issues.

Care workers received regular supervision, spot checks of competence and annual appraisals. The service had developed a career pathway so that care workers could progress in the organisation.

We saw that people who needed help to eat and drink or with maintaining their holistic health, received this from the care workers.

Is the service caring?

Good

The service was caring.

People and their relatives told us that the care workers were caring, respected their privacy and dignity and promoted their independence.

The service tried to employ care workers with the right values and to match people with the care workers they liked the most.

The service referred people to advocates when they needed them. We saw positive feedback from relatives of people the service had supported at the end of their lives.

Is the service responsive?

Good

The service was responsive.

The service had implemented a new electronic care records system. We saw that care plans were detailed, person-centred and individualised.

People told us their care plans were reviewed regularly, were flexible and that they could make changes to them if they wished.

The service dealt with complaints according to their complaints policy. People and their relatives said they felt able to express concerns when they had them and that the service responded appropriately.

Is the service well-led?

Good

The service was well-led.

The service was highly committed to continuous improvement and involved care workers, people and their relatives in the process.

Innovative electronic systems were used to audit the quality and safety of the service in real time.

Care provided was evidence-based. The service kept a 'boasting book' whereby staff were encouraged to celebrate and share their own good practice with their colleagues.

Faster than a Cat t/a Bluebird Care (Trafford)

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 31 May and 01 June 2016; it was unannounced, which meant the service did not know we were coming. The inspection team consisted of one adult social care inspector and 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. The expert by experience on this inspection was a retired nurse and had been a carer for an older relative.

Prior to the inspection, the registered provider had completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, such as what the service does well and the improvements they plan to make.

As part of the inspection we reviewed the information we held about the service. This included contacting the local authority safeguarding team, Healthwatch Trafford and the local clinical commissioning group. We also contacted four other healthcare professionals involved with the people using the service. Those that responded gave very positive feedback.

During our inspection we visited four people who used the service in their homes. The expert by experience spoke over the telephone with six people who used the service, three care workers and six people's relatives. We also spoke with the managing director, registered manager, deputy manager and two care workers at the office.

As part of the inspection we reviewed seven people's care files at the office and four in people's homes when

we visited them (with their permission). We also viewed four care workers' recruitment, supervision and appraisal records, various policies and procedures, care worker training records, three people's medicine administration records, audit and monitoring records and other documents relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People using the service told us they felt safe with the care workers. One person said, "They are all decent people and they are all very good. I feel safe with them", and a second person told us, "I know the checks that are made and the people they recruit. It's done properly." Relatives also told us they thought their family members who used the service were safe. One relative said, "My relative is safe with the carers. They treat [them] well and have a little chat with [them], which is nice."

People told us they were happy with the support they received from Bluebird Care (Trafford) with their medicines. One person said, "They always check to see if my medicines have been delivered properly", and a second person told us, "They take all the tablets out the blister pack for me and watch me take it."

As part of this inspection, we looked at how medicines were managed by the service. In April 2016 the service had changed to an all-electronic system for care plans and medicine administration charts (MARs). Care workers accessed these records on smartphones. We checked MARs for five people on the electronic system. We could see that care workers made a note on the system when they had administered medicines and that the time it was done and their name was recorded automatically. Any omissions generated alerts which were investigated the same day by the manager checking the system; we saw alerts that had occurred since the system came online were almost entirely due to care workers forgetting to update the system. We also saw that these types of alerts had decreased significantly in the weeks prior to the inspection as care workers got used to the new system.

The majority of medicines were managed safely, although we did identity some issues. One person with complex health issues whose MAR we looked at received a medicine 'as required' for pain; this meant that the medicine was to be taken when the person asked for it or had certain symptoms. When medicines are administered 'as required' to people there needs to be a specific care plan or protocol in place to describe what the medicine is for, how often it can be taken and the maximum daily dose. The MAR we checked did contain a protocol for the 'as required' painkiller but it did not state what the medicine was for or contain instructions on symptoms or behaviours the person might show when they needed the medicine. We spoke with the registered manager about this and she said that the protocol would be reviewed and updated and that all other protocols for 'as required' medicines would be checked to make sure they contained the relevant information.

We visited people in their homes as part of the inspection and checked the medicines of people who the service supported with taking them (with their permission). Most medicines came in blister packs and we saw that they were up to date. We noted that one person had an arrangement whereby care workers would leave medicines that were to be taken at times they were not there in a place the person could find them and take them. We saw that one of this person's medicines had changed the week prior to the inspection from a tablet taken with their other morning medicines to one that needed to be taken so many hours before and after food. The person told us that the care workers left the tablet in an agreed location for them to take at 11am, after the care workers had gone, and that this was working well. When we checked whether the electronic system had been updated, we saw that the new medicine was listed, but the instructions

about leaving it out for the person to take at a different time had not been added. This meant that care workers unfamiliar with the person might give the person this medicine to take with their other morning medicines by mistake. We saw that instructions for all the other medicines the person took when the care workers were not there were included on the system. We raised this with the deputy manager at the office and they amended the electronic system there and then, which meant that it would update on care workers' smartphones straightaway.

We saw that risks to people had been assessed by the service and control measures had been put in place. People's care plans on the electronic system included risk assessments for various aspects of their care, such as moving and handling, good hygiene and the safe use of products such as shampoo and deodorant. The internal areas of people's homes were also risk assessed, as were external areas, if required. We saw risk assessments for risks specific to individuals; for example, a swallowing risk assessment and care plan for a person who needed dietary modifications to make eating and drinking safer for them. We saw examples of positive risk taking; for example, a person supported with moving and handling equipment in order to improve their access to other places, despite their risk of using such equipment being judged to be higher than that of other people. It was deemed that the benefits outweighed the risks.

We saw that the service had gone the extra mile to protect staff from risks associated with supporting people. One person sometimes displayed behaviours that may challenge others and could at times grip care workers firmly around their arms. We saw that the service had invested in arm guards so that care workers could meet the person's needs safely. The service also supplied care workers with circuit breakers for use when supporting people with their own electrical appliances. This meant that the service tried to mitigate risks for both their staff and the people using the service.

We did note that one person using the service was being supported by staff to use a hot water bottle for pain relief. The hot water bottle use was documented in the person's care plan but there was no risk assessment in place for this. Hot water bottles that are not used safely can pose a serious risk to people. However, if a risk assessment is completed and the person is aware of the risks, they can choose to use them if a service is willing to support them. Not having a risk assessment in place meant that the person might be at risk of scalding if the hot water bottle was not prepared safely by care workers.

Care workers we spoke with could describe the different forms of abuse the people they supported may be vulnerable to and said they would report any concerns to a manager straightaway. One care worker said, "Besides the obvious things like unusual bruises, I would watch out for changes in behaviour, loss of appetite; that sort of thing", and a second told us, "I check things around the house before I leave to make sure windows and doors are properly locked." We checked the records at the office and saw that care workers had all received safeguarding training. The registered manager knew how to report any concerns to the local authority and to the Care Quality Commission, as is required, and we saw she had done so correctly when it was needed. This meant that the service was supporting the people safely.

We asked people who were assisted with their personal care by the service if care workers wore personal protective equipment, such as gloves and aprons, when they did this. The people we spoke with told us they did. One person said, "They always put a pinny (apron) on and they always wear gloves", and a second person told us, "They're under instruction to wear gloves and aprons and will change gloves between jobs." This meant people were supported by care workers wearing the right protective equipment.

One aspect of infection control audited by the service was the compliance of the care workers with the infection control policy. The policy stated that care workers must not wear long sleeves, nail varnish or false nails. False nails and nail varnish may pose an infection control hazard as bacteria and other

microorganisms can live underneath them and may infect the people being supported by the care worker. Records showed that when one care worker was spot checked at the start of March 2016 they were wearing nail varnish. This was then discussed with them at a supervision meeting in April 2016. We noted that two subsequent spot checks at the beginning of May 2016 had shown further issues with the care worker's nails. This was then escalated and at the time of our inspection, was in the process of being addressed with the care worker. This meant the provider enforced organisational policies and procedures to ensure the risk of the spread of infection was minimised.

We wanted to see if the service recruited new staff safely so we checked the records of four care workers. We saw that recruitment files included all the necessary documents, including proof of identity, references from previous employers and a Disclosure and Barring Service check. This meant that the service made all the right checks to ensure new employees were suitable to work with vulnerable people.

People we spoke with told us they saw a regular team of care workers. All of the people said that care workers stayed for the full allotted time; one person told us, "There's no call crunching. If I book an hour, I get an hour." In the customer guide that each person had it stated care workers would aim to arrive at the time requested by the person, or be a maximum of 30 minutes either side of that time. All of the people who told us that care workers were not always on time commented on the problems with traffic in their area. One person said, "Occasionally they're late, but the traffic is so awful around here."

Another person told us that earlier in 2016 they felt there had been issues with scheduling care visits, in that care workers were travelling long distances between calls, which added to lateness. This was echoed by feedback from care workers in surveys they had completed in January and April 2016. The service had responded to the surveys by working closely with the member of staff responsible for planning visits to improve scheduling to reduce travel time and lateness. The person who had commented on the scheduling told us, "I think it has improved recently." The registered manager showed us records which supported this. The scheduling system which logged when calls were missed altogether also classed calls made outside the 30 minute as missed. We saw that between 01 March 2016 and the date of our inspection the service had completed over 11,000 calls and of these, only three calls were actually missed due to an administrative oversight and three were outside of the 30 minute window. This showed that the percentage of calls outside the call windows people had agreed to was extremely small.

Good

Is the service effective?

Our findings

People we spoke with said they thought the care workers were well trained. One person commented, "It's getting better because they're getting more tuition, like dementia and all that", and a second person told us, "I think it quite impresses me, the amount of training they do now", and then added, "I know they've done dementia, end of life and handling (moving and handling)."

Care workers told us they had received training in all the mandatory subject areas, such as safeguarding, moving and handling, first aid and food hygiene, as well as specialist courses that enabled them to support people with more complex needs. One care worker said, "We've been asked if we want to do more training to work with young people with autism and other problems. I think that's a great opportunity and there is so much training and support." Training was either provided in-house by members of the management, two of whom were qualified teachers, plus managers who had received training to train others, or was sourced externally. We saw that every training course was evaluated by staff so that the service could identify good practice or required improvements.

Records showed that care workers were up to date with their mandatory training and the registered manager explained that updates were held at least annually for these subjects. The service was also keen to train its staff to support people with more complex needs. We saw the service had worked with a training provider to develop a three day course covering subjects such as epilepsy, diabetes, heart disease and Parkinson's disease. The registered manager told us, "We wanted an overview of the more common problems our customers have." Some of the care workers had already attended this course and the plan was that all of them would receive it as soon as further dates could be arranged.

Care workers received specialist training depending on the needs of the people they supported regularly. We saw that some care workers had received training on end of life care, stoma care and percutaneous endoscopic gastrostomy (PEG) feeding, where people receive food and fluids through a tube inserted into their stomachs.

Specialist training had been sourced for care workers supporting a person with complex needs. This training had commenced prior to the person's discharge from hospital and had involved their family at the expense of the provider, so the care workers and family could work as a team to support the person. The managing director described how he and the registered manager had attended training on a specific neurological condition so that the service could provide more informed support and advice to a person using the service and their family. We saw feedback from this person had been highly complimentary about the standard of care they had received. This showed us the service was committed to providing care workers with the training they needed to support the people and went the extra mile to equip staff to support people with more complex needs.

The registered manager had worked hard to incorporate the requirements of the Care Certificate into the service's induction process. She explained that the induction consisted of 5 days' of office-based training which covered all of the core units except first aid, which was delivered as a separate training course.

Attendance was mandatory, regardless of care workers' past experience. New care workers would then work alongside another care worker or assessor for up to three months until competency assessments of their work showed they were safe and competent to support people alone. Care Certificate files and competency assessments of care workers new to care that we saw were comprehensive and detailed, which showed that the service provided an induction which prepared new staff to support people appropriately.

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 make particular decisions any made on their behalf must be in their best interests and as least restrictive as possible.

We asked care workers how the MCA affected the people they supported. One care worker described explaining care tasks to people and providing choices as a way of supporting people to make their own decisions. Another care worker emphasised that it was important to give people options, even when it was known that they lacked capacity to make all of their own decisions. All of the care workers had been trained on the MCA and the registered manager showed us small leaflets each care worker was given which summarised the legislation.

As the service was in the process of making the transition from a paper-based system to electronic care records, we looked at both types of records for seven people to see if any were affected by the MCA. Some of the people supported by the service were known to lack capacity to make certain decisions and we could see who these people were from the care records. Detail was still being added to care records on the electronic system about people's capacity and how they made decisions, but it was still available for care workers to access, either on the system that scheduled their visits or in the paper copy of the care plan kept in people's homes. We saw the service had completed assessments of some people's mental capacity to make certain decisions and had worked with other healthcare professionals to input into best interest decisions that had been made when individuals lacked capacity. The new electronic system contained templates the service could use to record assessments of people's capacity when it was thought necessary and the registered manager said that the service was working through these assessments as they transferred all of the detail across to the new electronic system. This meant that the service was compliant with the requirements of the MCA.

People can only be deprived of their liberty so they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in community settings are called the Deprivation of Liberty Safeguards in Domestic Settings (DiDS). In domiciliary care, the care provider must request that the local authority applies to the Court of Protection for DiDS authorisation if they think the person's liberty must be deprived to keep them safe.

The registered manager said at the time of our inspection that one application for DiDS was being made to the Court of Protection and that the service had been involved by providing information about the person's care needs. She said the service would inform the local authority if other people lacking capacity were thought to need their liberty deprived in order to keep them safe. This meant that the service was aware of, and complied with, the MCA as it was applied in community settings.

Care workers told us and records showed that they received regular supervision from managers and an annual appraisal. We looked at four care workers' personnel files and could see that some form of supervision had taken place at least monthly, which consisted of either a spot check by a supervisor at a person's house or a one-to-one meeting in the office with a supervisor or manager. Annual appraisals

assessed care worker's strengths and areas for development and care workers were invited to them by a letter which contained a self-assessment form they were expected to complete prior to the meeting. People and staff also described how various employees had been promoted from within the organisation and we saw in the business plan that the managing director had created a career pathway for care workers to move up in the organisation. This meant that care workers were supported by the service to do their jobs and to progress in their careers.

As part of their care packages, some people were supported by staff with meals and drinks. People's care plans told staff what support people needed, for example, whether food needed to be taken from a freezer and defrosted in advance or prepared in a certain way. Care plans were also specific about people's food likes and dislikes and described how they liked their drinks to be prepared. One person said, "They cook my meals for me. They give me choices", and then added, "They check the dates on food in the fridge for me." Another person told us, "They quite often give me choices and tell me what's in the fridge or freezer." This meant that people were supported to eat and drink in a person-centred way.

The service's involvement with other healthcare professionals supporting the people varied depending on each individual's needs and mental capacity. Most of the people we spoke with said they managed their own GP and dentist appointments, although one person said they had used what they called, "The Bluebird taxi", to access healthcare appointments with care workers. Another person had been having problems cutting their toenails and described to us how a care worker had helped them to access a podiatrist. A third person commented, "If they think I'm not too well then they let the people at the office know." This reflected what a care worker told us, who said that when people needed to see other healthcare professionals, they communicated this to staff at the office who made the arrangements. Healthcare appointments people needed support with were logged on the new electronic system and any regular appointments were listed as separate visits. We saw records which showed communication between staff from the service and various healthcare professionals, including GPs, community nurses and the dementia crisis team. This meant that people were supported by the service to maintain their holistic health if they needed it.

Good

Is the service caring?

Our findings

People told us that care workers were caring. They also were complimentary about the staff they spoke with if they telephoned the office. Comments included, "The care staff are brilliant and the office people are very approachable and helpful", "They'll do anything for me", "I don't mind which carer comes because they are all really kind and thoughtful", and, "They are superb. I just can't sing their praises enough."

We asked people if care workers respected their dignity and privacy when providing support and people said that they did. All of the people we spoke with said that care workers knocked on doors, even when they could access their houses with keys. One person said, "They knock on the door and come in and shout who they are", and a second person told us, "If I'm in the shower (when the care worker arrives) she'll knock and say 'it's me'." The service was accredited under the Dignity in Care scheme by Trafford Council in 2014; Dignity in Care awards recognise care providers willing to go the extra mile to make sure people are treated in a dignified and respectful way. This meant that the service respected people's privacy and dignity.

People told us how they developed close relationships with their care workers. One person told us, "I know them all. They're like friends to me"; they then added, "I can pull their leg", and, "I have a laugh with them." Another person described how they liked hearing about care workers' lives. They told us, "I'm nosy and ask about their families. I like to hear about how they are. It keeps me going." Two people described how they had become attached to care workers who had then been promoted within the company to office roles. Both had been pleased for the care workers' achievements but had been upset to lose them. One person joked, "It's happened twice now. I've told the office it has to stop!" This person also described the little things care workers had done to make them feel special. They told us, "I consider them my friends. One brought me a piece of birthday cake and I get Christmas cards." This showed us that care workers tried hard to form caring relationships with the people they supported.

The registered manager described how the service tried to ensure that each person was supported by a small team of care workers with the right values. She explained that the service's recruitment process involved prospective care workers undergoing personality testing to see if they were suitable to work in a caring role. We saw that questions assessed applicants' conscientiousness, stability and team-working ability. We asked the registered manager if the outcome of the test was used to filter out people who appeared to be unsuitable and she said yes. She explained that in the three years they had used the system and gone against the outcome because a candidate interviewed well, they had sometimes gone on to experience problems with the care worker at a later date.

Care workers could access people's care plans and personal information via an application on their smartphones. The service ensured that smartphones were password protected and could be locked remotely if they were lost or stolen. We saw the registered manager had sent a memo to staff reminding them of their responsibilities with respect to the Data Protection Act, such as having an email account only they could access and deleting rotas as soon as they were out of date. The office we inspected was secure and all information about the people was either locked away or kept on password-protected computers. This meant that the service protected the confidentiality of the people who used it.

People described how care workers encouraged them to remain independent as much as possible. One person told us, "They (the care workers) think if [I] can do it, they're doing me good. The idea is to get me moving", and a second person said, "It's a joint thing. They're not too assertive with it but they do encourage me. They do notice if I need help." Care workers also gave examples of how they promoted people's independence. One described how they would encourage a person to wash the parts of their body they could reach or choose what to wear and a second said, "It's not to take complete control; to get them involved as much as possible." This meant that care workers supported people to retain their independence.

The registered manager said that the service would refer people to advocates if it was felt they were needed, but that this did not happen often as most people had family members or attorneys who advocated for them. She gave examples of when people who lacked mental capacity had been referred to advocacy services for independent support when best interests decisions were made on their behalf or if they needed help with their finances. We saw that information on advocacy services was included in the customer guide each person had in their homes. This meant that people were routinely provided with information on advocacy and referred to advocates by the service when they needed them.

None of the people the service was supporting at the time of our inspection was received end of life care, but staff told us and records showed that the service had provided people with this type of support. We saw care plans for people the service had supported to die at home were very detailed and person-centred, describing how people wanted to be supported by care workers. Staff who provided end of life care had received specialist training and we saw the registered manager had email staff the latest NICE clinical guidelines on care of the dying the day they were released in December 2015. Relatives of people the service had supported at their end of life had provided reviews of their and their family member's experiences. Feedback included, "I will never forget the kindness and compassion shown to us all on the day that our relative died. The support we received from Bluebird allowed us to be strong and they helped [them] to pass away with dignity", "Having a small group of carers who knew [my relative] well was very important but I know it was hard for them when [my relative] passed away", and, "Our thanks to the staff at Bluebird Care for all the love and care they showed our wonderful [relative] in the last days of [their] life." This meant that the service provided end of life care which supported people to die with dignity in their own homes.

Good

Is the service responsive?

Our findings

People described how they had been involved in planning their own care. One person told us, "I've got a care plan in there (indicated folder of documents). I have read it", a second person commented, "They came and talked about what we needed and then they come every now and again to see if everything is all right", and a third person said, "I'm sure I could change my care plan. I'd just ring them up (the office) and tell them."

At the time of our inspection the service was in transition from paper records to an electronic care file system. Because not everything had been transferred across, we looked at people's paper records and on the electronic system. We saw that people's care records were well structured, concise and easy to read. Information about the people, their care needs and the support required from care workers was individualised and person-centred and each plan of care had outcomes listed for the person. We saw these included goals such as 'to be clean and comfortable' and 'to access the community.' Care workers told us that they read people's care plans before they supported them for the first time.

Care records also contained details about what was important to each person, as well as their past medical history and the family and other healthcare professionals involved in their care. People's plans were individualised depending on their needs, so some had medicine or nutrition care plans whilst others did not. Both electronic and paper care files contained risk assessments. Each visit was described in a step-by-step fashion on the care plans, so that care workers would know exactly what to do to support the person. The electronic system was laid out in such a way that users could look at separate aspects of people's care, such as medicines, dates and times of visits, tasks for each visit or risk assessments, or they could select an option that would bring all the information together into one care plan document. We found the system very easy to navigate. This meant that the care planning system the service was moving to was fit for purpose.

Prior to April 2016, care workers had kept paper records of their visits in each person's home which they updated each visit. Since the electronic system was implemented, care visits were recorded by checking off each task, including any medicines the person was supported to take, in the care plan for the visit using the application on their smartphones. This created a timed and dated record of the visit and logged which member of staff it was. There was also a box for free text at the end of the visit record for staff to record any other relevant information. We asked what would happen if the care worker could not get a phone signal or Wi-Fi, or if they could not access the records due to a smartphone problem. The managing director explained that the system updated itself on each smartphone when they had a signal but was still available for use when not online. Any updates care workers recorded would automatically upload to the system when they got a signal again. The deputy manager told us that if care workers had technical issues and could not access the system at all, they could ring the on-call number and speak to a supervisor or manager who would access the system and talk them through the visit. This would even be possible at nights and weekends as staff members on-call were issued with iPads they took home with them. This meant that the new electronic system created an audit trail in real time for each visit which could be checked by office staff to ensure care workers had supported people according to their care plans and the service had measures in place should the technology not be available for any reason.

People, their relatives and other healthcare professionals could request free access to a person's electronic daily records, with the permission of that person. A folder in each person's house contained a tag a smartphone user could swipe which would allow them to request access from the office. The office would then check with the person and, if permission was granted, the relative or healthcare professional could access the person's daily records. The managing director explained that access was restricted to a narrow geographical radius around the person's house, but that unrestricted access could be given to healthcare professionals or to relatives living further afield, if the person consented. We heard that one relative involved with the care of a family member had complained to the service about the new system, saying that they could not access it. We saw that the service had written to the complainant and re-instigated paper records for the person within 48 hours of receiving the feedback. The registered manager was also in the process of checking with people that they were happy with the new arrangements and said they would revert to paper records for those that wanted to. This meant that service had embraced new technology but respected the wishes of those who preferred the old system.

We asked people what they thought of the new electronic system. One person told us, "I preferred the file to the phone", and a second person said, "Sometimes they don't talk to me as much." With further discussion each person explained that when the service initially switched to the electronic system some care workers had struggled with the smartphones which had made them seem distracted. However, people told us this had since improved. One person said, "It's quite good the new system", and, "I've got used to it and they're getting quicker." We discussed this with the managing director and he showed us that the service had sent all of the people letters on four separate occasions to tell the about the transition to the electronic system. Care workers we spoke with said of the new system, "It's good. We're trying to get out heads round it", and, "It's a lot more efficient. A good way of recording information in real time", which showed us they supported the use of new technology. One of the healthcare professionals we contacted for feedback for this inspection wrote their team was, "Impressed with their electronic care system that carers have on their phones to access care plans to ensure they are providing person centred care." This meant that although some people had issues with the new system initially, most were now fully supportive.

People told us their care plans were flexible and they were reviewed regularly. One person commented, "One of the supervisors came before they updated my plan." We saw that the new system allowed people's care plans to be updated in 'real time', in that changes made on the computer in the office automatically updated the information on care workers' smartphones if they had signal or Wi-Fi. The real time nature of the system also meant that any omissions by the care workers when logging completion of the tasks listed for each visit could be addressed the same day. We saw that any gaps in recording created an alert on a system monitored by office staff; they could then contact the care worker to check that all care required had been given. We saw this was much more responsive than a paper-based system whereby updated care plans needed to be delivered to people's houses and any omissions in care would not be noted until the paper records were periodically taken back to the office.

None of the people or relatives we spoke with said they'd ever made a formal complaint to the service. People and their relatives described providing feedback or asking for support to be given in a different way and were satisfied with how the service responded. One person told us, "Any niggles are soon sorted out", and a second person said, "I tell [the deputy manager] if I have any little concerns." Other examples we heard about included a person asking for care workers of one gender and a relative asking for care workers who did not smoke, both of which were actioned by the service. This showed us the service was responsive to feedback in order to provide people the support they asked for.

We saw the service collated complaints into categories in order to analyse trends. Nine formal complaints had been received in 2015. We checked the service's complaints policy and found that the service had

followed their policy in terms of documenting, investigating and responding to complaints.

Good

Is the service well-led?

Our findings

People told us they thought the service was very well managed and that staff were professional. One person said of the registered manager, "She's always been helpful when I've rang." Other feedback received by the service included, "The quality of the service was always excellent and every time I had cause to ring the office I was very well treated", "Bluebird Care (Trafford) are a well organised agency with first class staff at all levels", and, "I have been impressed and moved by the professionalism, diversity and flexibility of the carers and the support they offer."

Healthcare professionals we contacted as part of the inspection also praised the service highly. Comments included, "Very professional", "Carers have been punctual and provided high quality care", "Well trained staff, polite and professional", "I'm impressed with the way they respond to issues and enquiries", and, "Care is respectful, timely and patient centred." One healthcare professional said of the registered manager, "My experience, with the manager especially, has been really good."

We were impressed by service's commitment to improve. The managing director and registered manager worked hard as a team to drive continuous improvement at all levels of the service. Each year the managing director and registered manager spent two or three days away to analyse successes and areas for development from the previous year and to plan for the year ahead. The service had a detailed five year business plan which the managing director had recently presented to the local care commissioning group. The managing director and registered manager met weekly to check progress against the plan to make sure any actions were on track. The managing director told us, "We're absolutely committed to planning where we're going."

We saw that the business plan was based upon a philosophy of care the managing director had developed, which he called, 'whole person care.' He told us, "We've developed a philosophy of how we provide care for people. We have a holistic view." The registered manager said of the managing director, "His values are right. He wants what's best for customers and carers." One healthcare professional we contacted described the managing director as, "Innovative and forward thinking." Care workers said of the vision and values of the service, "It's to promote independence as much as possible. To provide the right sort of care", and, "There is a culture of caring about the people we look after. I like the values of this organisation." An example of this was a memo we saw from the registered manager to care workers in February 2016. It ask them to see if any people using the service needed extra blankets to keep them warm as the service had purchased fleece blankets and provided them free to any people who asked for them. This meant the service had distinct vision and values which were understood and put into practice at all levels of the organisation.

The service recognised the importance of involving people using the service and staff at all levels of the organisation in continuous improvement. The registered manager had created an extensive plan of all the improvements the service wished to implement, such as expanding inclusiveness through embracing diversity, formation of a customer council (made up of people using the service) and the creation of lead roles for staff in areas like foot care and palliative care. She had used this plan to set up two projects: customer events and staff support, and customer safety, tools and outcome. We saw that the week prior to

our inspection, the registered manager had emailed staff to ask for volunteers to lead on these projects on behalf of the service. Volunteers would receive two to three paid days a month to work on the project and funds for any materials they may need. The registered manager told us, "We need all of our team to grow."

As part of the service's commitment to continuous improvement, it went to great lengths to generate feedback for quality assurance. People using the service received questionnaires to complete annually and they were asked for feedback at their six monthly review meetings. Going forward, the registered manager planned to undertake quarterly surveys of a sample of people using the service so that any issues could be identified sooner and the service could be more responsive. The service had created an online survey for people and their relatives to use and all stakeholders were encouraged by the service to leave feedback either written or online with an organisation which shared information with NHS Choices. We saw that the average rating for Bluebird Care (Trafford) on NHS Choices was five stars out of five, which meant that it was very highly rated by users of the service and their relatives.

The management team used the innovative new electronic care records system and the visit scheduling system to audit the quality and safety of the service. The registered manager showed us visit time statistics for April and May 2016 which were logged by a coordinator weekly and audited by the registered manager monthly. These evidenced that visits were on average four minutes longer than the time people paid for; the registered manager told us, "I'd much prefer it four minutes over than four minutes under." As discussed earlier in the report, the new system updated instantaneously so managers with oversight at the office could address issues with medicines or care tasks not being completed on the day the visit occurred, rather than weeks later during an audit of paper records. The managing director told us, "We get an immediate alert in real time if a customer has not had their medication. We need to know so we can do something about it." During our inspection we saw managers in the office using the new system to identify when care workers may have overlooked aspects of people's care. They contacted the care workers straightaway to check people had been supported according to their care plans. This meant that the service was using the new system to audit care records daily in order to maximise its responsiveness to the people.

The service had a collaborative approach to quality audit. We saw that tasks were shared between the management team then discussed with the registered manager at a weekly risk meeting so that she retained oversight. For example, care supervisors organised care worker supervisions and care plan review meetings with the people using the service and audited medicine records during supervision meetings. The outcome of supervisions and care review meetings was audited at the weekly risk meeting so that care worker and service user satisfaction could be assessed and any appropriate actions taken. The deputy manager responded to complaints and investigated accidents and incidents; these were also discussed at the weekly risk meeting with the registered manager where any trends were analysed. We looked at the minutes of the last three risk meetings; we could see that actions agreed upon were reviewed at the next meeting to ensure any changes or improvements were made. The registered manager said of the risk meetings, "It's to see what's going wrong, what we can change, what we can do better." The registered manager met weekly with the managing director, who was based in the same office, to update him about any issues or concerns. This meant that the service had a comprehensive system of audit which managers used to drive improvement.

An example of how the service used audit to benefit the people was the way the scheduling system was employed to maximise the consistency of the care workers that supported each individual. The registered manager explained that a statistic was calculated by the rota system which showed the number of different care workers a person had seen in a set length of time: the higher the number, the more different care workers the person had received. The provider had set a benchmark for this statistic and we saw that Bluebird Care (Trafford) checked weekly to ensure they were below it, meaning that people saw a smaller

number of care workers. We saw an example of when the system had identified that the number of care workers seen by one person was increasing. The registered manager had put measures in place and the number of different care workers the person saw was reduced. People told us, "I have a small team", "I see the same people", and, "I think continuity is important." This meant that the service used audit to ensure the people had small and consistent teams of care workers to support them and that the people appreciated this.

Bluebird Care (Trafford) is a franchise of the Bluebird Care homecare group. As part of the franchise agreement, Bluebird Care (Trafford) is audited at least annually by the franchise owner. We saw that the service had received 96% in its most recent audit, and as a result, had won the Bluebird Care Business of the Year 2016. This meant that Bluebird Care (Trafford) was judged to be the best out of over 200 similar franchised services.

We found there was an extremely open and supportive culture at the service. A member of the management team said that earlier in 2016 they had made an error which meant that a person did not receive the care visits they had requested. The person came to no harm as a result. The manager described how they had immediately informed the registered manager and then had chosen to call a meeting of the office staff to explain what they had learned from the incident in order to prevent others doing the same. The manager said they shared their experience to demonstrate that facing up to mistakes was the best way to deal with them. Other care staff fed back on the culture at the service. One commented, "My managers make me feel at ease and able to raise any queries, questions or concerns easily. I'm proud to work for a care company that have such high standards."

We saw that care workers were highly valued by the service. The service's business plan included a 'virtuous circle' whereby happy staff supported people well, which led to recommendations, more customers and a growing business. Care workers were paid above the national minimum wage, and this included travel time and training. They could claim for their fuel and had access to a company health insurance plan. Care workers told us how they were asked for their ideas on how to improve the service for the people. One care worker said, "We're always encouraged to give feedback on support plans", and described how they had added comments to daily records to alert the office staff when changes were required, which they then followed up with an email. Care workers were asked to feedback on the service in their supervision meetings, in team meetings and via an online portal which could be accessed at any time. They also received regular questionnaires, and we saw that when results had been analysed, the registered manager communicated the outcomes back to staff along with the changes the service was going to make as a result. For example, staff feedback in the January 2016 survey focused issues with travel time; we saw that when a subsequent survey was sent out in May 2016, it included the measures taken to improve visit scheduling to decrease travel time and a thank you to the staff for their feedback. Care workers we spoke with were very positive about the service. One told us, "[The managing director] is great to work for as a boss. [The registered manager's] brought the company on in leaps and bounds. No corners are cut", and a second said, "We have one manager who is a breath of fresh air. She has enthused everybody and has so many good ideas." This meant the service actively sought ideas and feedback from its staff to make improvements and staff felt valued as a result.

The registered manager ensured the care the service provided was evidenced-based. She listed the resources she accessed regularly, for example NICE guidelines and information from the Alzheimer's Society, and we saw examples of when they had been communicated to staff or used to underpin discussions with people and their relatives. Members of the management team had attended training sessions on neurological conditions and autism, as well as seminars and conferences on dementia and motor neurone disease. In April 2016 the managing director had become a senior associate member of the Royal Society of

Medicine; he told us, "This gives us greater access to knowledge and expertise in neurology." The registered manager and managing director were also keen to promote in-house good practice and had created what they called a 'boasting book.' This was a file which contained compliments from people, relatives and other healthcare professions as well as examples submitted by care workers or by managers in recognition of care workers' good practice. We saw that ideas and examples were circulated to the team of care workers and compliments were fed back to individuals when they were received. This meant that the service implemented national good practice and also sought to identify and share good practice in-house, in order to acknowledge and reward its own staff.