Bayford New Horizons Limited

Bluebird Care (Chichester)

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 14 and 15 May 2018.

This service is a domiciliary care agency based in Chichester, West Sussex. It provides personal care to people living in their own houses and flats in the community. At the time of the inspection it provided personal care to 114 people in their own homes, in the Chichester and mid West Sussex area. These people were aged between 30 and 100 years and had a range of care needs. Bluebird Care (Chichester) is part of a franchise brand of services of Bluebird Care which operate across the United Kingdom.

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.

People were consulted about their care and had agreed to the care being provided. The provider had policies and procedures regarding the Mental Capacity Act 2005 and care workers received training in this.

People said they received a reliable service although there were comments that some of the arrival time could be improved; care workers also reported not having sufficient travel time between each appointment. The provider was aware of this and had already acted to address this. The provider had introduced an IT system whereby care workers used a smart phone to access care records and to record the care tasks. The system enabled the administrative and management team to oversee all care appointments and alerted them if any calls or tasks had not been completed.

People and their relatives said they would recommend the service to others and reported they received a responsive and caring service. Comments from people included the following for example, "They do anything I ask. I'm fairly unsteady on my feet. If they get everything done that I need them and they still have time they will make me a cuppa and have a chat with me. When you're on your own it's good to know you have someone nice who you can trust coming in and they'll do what I ask."

People said they felt safe with the care workers and received safe care. Care workers had completed training in safeguarding procedures and knew what to do if they had any concerns about the safety of welfare of people.

Risks to people were assessed and there were details in care plans of how to mitigate these risks and keep people safe. These included procedures for transferring people and we observed care workers did this safely.

Care workers followed procedures to prevent and control infection.

The provider took action to look into any concerns such as safeguarding incidents.

Care workers were supported by a range of training courses and regular supervision. There was an induction procedure for new care workers as well as the monitoring and appraisal of their work. Staff felt supported and had access to management staff for advice and guidance.

People were supported with food and drink, where this was applicable, which was recorded in care records. Health care needs were monitored and referrals made to health care professionals.

The provider looked into and responded appropriately to complaints.

There were no people in receipt of end of life care and the provider had plans to train key staff in this and to register for accreditation with the Gold Standards Framework for end of life care.

People, their relatives and care workers stated the provider was open and responsive to any concerns raised or suggestions. People were consulted and involved in their care reviews and there was a system for asking people for their views about the service which was part of the ongoing monitoring of the agency.

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.

Risks to people were assessed and guidance was in place to mitigate these.

The service had policies and procedures on safeguarding people from possible abuse. Staff knew what to do if they suspected any abuse had occurred.

There were sufficient numbers of care workers to meet people's needs. Checks were made that newly appointed staff were suitable to work in care.

People said they were satisfied with the support they received with their medicines.

Care workers followed procedures to prevent and control infection.

Incidents were looked into and action taken to make improvements.

Is the service effective?

Good

The service was Effective.

People were consulted and consented to care. There were policies and procedures regarding the Mental Capacity Act 2005 (MCA) and staff were trained in this.

The provider utilised innovative technology to plan and monitor the care people received.

Care workers had access to current guidance and training regarding care procedures. Regular supervision and appraisal of care workers took place.

People were supported with food and drink where this applied.

Healthcare needs were monitored and people were supported to access health care services where needed.

Is the service caring?

Good

The service was Caring.

Care workers demonstrated a caring and compassionate approach to people.

People were involved in decisions about their care and were supported to maintain their independence. People's privacy and dignity was promoted by care workers.

Is the service responsive?

Good

The service was Responsive.

People received care which reflected their preferences. Care plans gave details about the care people needed.

The provider's IT system for care records enabled care to be responsive to people's changing needs.

There was a system for dealing with and resolving complaints.

The provider had plans to develop care workers skills in end of life care.

Is the service well-led?

Good

The service was Well-led.

The provider had systems to monitor the quality and safety of the service.

People's views were sought as part of the quality monitoring process. The provider had plans to involve people, their relatives and care workers in the running of the service.

The provider took steps to improve and develop the service such as by the use of technology.

The provider worked with other agencies such as safeguarding investigations.

Bluebird Care (Chichester)

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 was 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 15 and 16 May April 2018 and was announced. We gave the service 48 hours notice of the inspection visit because we needed to make arrangements to visit people in their own homes and to ensure staff would be at the provider's office.

The inspection was carried out by one inspector and an Expert by Experience who carried out telephone interviews with ten people (or their relative) who received a service from Bluebird Care (Chichester). An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we checked information that we held about the home and the service provider. This included information from other agencies and statutory notifications sent to us by the registered manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we visited two people in their homes at the time they were receiving care from care workers and observed how they supported people. We also spoke with a relative of someone who received care.

We sent survey questionnaires to 50 people and 16 of these were completed and returned to us. We also sent survey questionnaires to 50 relatives and one of these was completed and returned. Forty-two surveys were sent to staff and seven returned. The collated information contained in these surveys has been used in the inspection report.

On day two of the inspection we visited the provider's office where we spoke with the registered manager, the operations director and the provider's director. We spoke also with five care workers and a supervisor.

We looked at the care plans and associated records for ten people. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, incidents, records of medicines administered to people and complaints. We looked at staff training records and staff supervision records.

Good

Is the service safe?

Our findings

We looked at the service's medicines procedures. Staff who gave or handled medicines to people completed a competency assessment before they were able to do this. The provider had policies and procedures regarding the handling and giving medicines to people. People and their relatives said they received help with medicines when this was needed. One relative said care workers had helped sort out a problem with a supply of medicine by working outside the agreed times which ensured the person got the correct medicine from the pharmacist. The relative confirmed the provider did not charge for this additional time.

Care records showed risks to people were assessed and there was corresponding action for staff take to mitigate the risks. These included falls risk assessments and moving and handling assessments plus care plan guidance about this. We observed staff using a hoist to transfer someone which was completed safely. Moving and handling equipment was provided to people in their homes. The risks of pressure damage to people's skin was assessed and there was care plan guidance about this. This included guidance for when people needed to be repositioned and when staff should check for any damage to people's skin.

The provider used an information technology system whereby each care worker had a smartphone which included their duty roster as well as the care plan for each person. The system enabled the administrative and management staff to have an oversight of the times care workers arrived and left as well as the completion of care procedures. Any 'missed' or 'late' calls to people were highlighted by the system. For example, we saw how the management team ensured a person was visited as the care worker had not 'logged in' on the smart phone when they were at the person's address. Care workers told us the system worked well. The system allowed people and their relatives to look at the records and to enter any relevant information or messages for care workers. This helped ensure people received safe and reliable care.

People said they received a weekly rota with the names and times of the care workers who would be visiting them. Feedback from people and care workers was variable about the reliability of the service they received. Each of the 12 people, or their relative, said the service was
generally reliable with a consistent staff team who they knew well. For example, one person said, "I get sent a schedule of who will be coming and the time for the following week. This isn't set in stone and it can vary a little but you have to allow for traffic hold ups and I know if they were going to be very late I would get a call."

Forty-four per cent of people who returned a survey to us said the care workers did not arrive on time but this data did not specify how late care workers were. We looked at the care records for 10 people and saw recent care visits were carried out at the times agreed with the person.

We received surveys from seven care workers and two of these said their work schedule did not give them enough time to arrive and stay for the agreed times. Two of the five care workers we spoke to during this inspection said travel time and their work schedule could be a problem but that this was resolved when they raised it. The provider said they were aware of the issue of travel time for care workers having an impact on their schedule and that this had already addressed which was also reflected by comments made by the care workers.

People and their relatives said they felt safe with the care workers. For example, people made the following comments: "They treat me very well. I can't think of an occasion when I've not felt settled with them." Another person said, "The staff treat us like friends. There is very good interaction with them. I feel very safe with them around. "A third person said, "They are very good and go at my pace. They help to dry me, make my bed, they'll make tea and chat with me. The fact that they are around when I'm having a shower makes me feel very safe. They don't go poking around and that too assurances me and gives me confidence." People also said the provider listened to them and acted if they asked when people asked for a different care worker.

Staff were trained in safeguarding and had a good awareness of how to report and deal with concerns about people's safety or welfare.

We looked at the staff recruitment procedures. References were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting. There was a record of staff being interviewed to assess their suitability to work in a care setting.

Staff received training in procedures regarding the prevention of infection. Each person we spoke with said staff followed hygiene procedures of using disposable gloves and aprons. For example, one person commented, "They wear gloves and aprons. They have very high standards, better
than I observed in the hospital." We observed care workers followed infection control procedures by wearing appropriate disposable personal protective aprons and gloves.

There was evidence the provider had acted to raise concerns by making appropriate referrals to the local authority safeguarding team which were looked into and an appropriate response made including any actions and learning points.

Good

Is the service effective?

Our findings

People told us they were consulted and involved in any decisions about their care and had agreed to their care plan. People had signed to consent to their care for various aspects such as support with medicines and personal care.

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. Care records showed people's capacity was considered and each care record we looked at stated the person had capacity to agree to their care. Care workers were trained in the MCA and there was 'easy read' literature on the MCA at the office for staff to see. Whilst care workers knew the importance of consulting people when they supported someone, they did not, however, have an understanding of the principles of the legislation and when it would apply. This meant care workers did not know how the MCA might apply to people in their care when they did not have capacity to consent to their care and treatment. We therefore recommend care workers complete further training in the MCA to ensure they have an understanding of the main principles of the legislation and how it would apply to their work.

The provider used an interactive information technology system whereby the management team were able to monitor in 'real time' when people received care. This helped ensure people's needs were met. This system also allowed people and their relatives to access care records and to add any additional information so care workers were updated with care needs.

The provider had policies and procedures regarding equality and diversity and this subject was included in the care worker's induction procedure. There was also a policy called, 'Fair access, Diversity and Inclusion'. Staff showed they were committed to treating people equally irrespective of age, disability or gender. For example, care workers said people's rights to a good standard of care were acknowledged in the way they treated people irrespective of age or disability.

Each person who completed a survey said care workers had the skills and knowledge to provide the care they needed.

Care records showed people's needs were assessed before a care package being agreed with them. Care plans were devised to meet those needs and people confirmed they received the care they needed. Staff had access to training which included current guidance on care procedures and information from organisations such as the National Institute for Clinical Excellence (NICE). Newly appointed care workers received an induction using the Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the minimum standard that should be covered as part of induction training of new care workers. Care workers confirmed they received an induction which involved a variety of training courses and a period of 'shadowing' more experienced staff. This was followed by an observational assessment and confirmation of the care worker's competency before working in an

unsupervised capacity. Records of these assessments were held with care worker's records. Care workers were also subject to ongoing monitoring of their performance by observation of their work with people.

Staff training included courses considered mandatory for care workers by the agency in medicines procedures, safe moving and handling of people, safeguarding people, health and safety, the prevention of infection, food safety and working with people living with dementia. These were recorded on a spreadsheet so the management team could monitor this. Training was updated as required. Care workers also had access to training in more specialist areas such as the use of feeding people with a percutaneous endoscopic gastrostomy (PEG) and in dealing with people's behaviour which could be challenging. The provider held monthly meetings where staff were supported to discuss relevant topics at the office, such as care procedures, privacy and dignity, and, safeguarding.

The provider employed 36 care workers and three of these had a National Vocational Qualification (NVQ) or Diploma in Health and Social Care at levels 2 or above. The registered manager had completed NVQ levels 2, 4 and 5, as well as a health and safety at level 4 and a management qualification. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. The provider stated there were plans to support more staff to attain a Diploma in Health and Social Care.

Care workers said the training they received was of a good standard and that they could discuss their training needs and how these would be met.

Records showed care workers had regular supervision and appraisal of their work. Care workers said they felt supported and confirmed they attended supervision where they could discuss their work and also said they could ask their line manager for advice and support as and when this was needed.

Care records included details about the support people needed with food and drink such as the preparation of meals.

Care records included details of any relevant medical history. There were records of contact with health care professionals where this was needed such as the person's GP and the provider had plans to develop this further by writing to each person's GP with details of the person's needs and support they received.

Good

Is the service caring?

Our findings

People and their relatives described the care workers as kind, empathic and compassionate. For example, one relative described the care workers as follows, "They're great. Kind. Compassionate. They laugh and joke. Really caring. They feel for him." Another comment from a person was, "I've been with Bluebird care for 6 years. They're very kind and helpful. I don't always have the same girl but most are really nice and very respectful. As I get to know them better we have a bit of fun."
We observed care workers were kind and respectful to people and there was a rapport between them. People said they got to know the care workers well which they valued and people also said the provider responded if they wanted a change of care worker. This showed the provider listened to what people said and made changes based on people's preferences.

Care workers said they treated people with respect and how they would like to be treated or how a member of their family would be treated. Care workers also demonstrated their commitment to the people they provided care to by "going over and above to go out of their way to help people." This was also reflected in comments made by people and their relatives.

Care records were individualised and included details of the preferences of how people would like to be treated, under headings such as, 'What is important to me.' Care plans also included details of those areas of personal care and support which people could do themselves so they could maintain their independence. Each person who returned a survey said the care and support they received helped them to as independent as they could be.
People said they were consulted about their care and were involved in decision making about their care. This was evident in care records showed people were involved in discussions and decision making about their care and had signed a record to acknowledge this.

We received positive comments from people and their relatives regarding people's dignity and privacy being respected. For example, a relative stated, "My father is absolutely treated with respect and dignity and, yes, I would say his privacy is respected." Another relative said care workers were good at giving people privacy when visitors came to their house. Ninety three per cent of those who returned a survey to us said the care workers treated them with respect and dignity. The provider had policies and procedures regarding privacy and dignity of the people who received a service. This had also been covered in one of the topics of the month team discussions. Care workers said they received training in the dignity and respect of people. Staff also referred to the importance of promoting people's privacy and said they would use curtains or a towel to screen someone when providing personal care.

Good

Is the service responsive?

Our findings

People told us they received responsive care which was tailored to meet their needs. For example, one person said, "From when the care first started they asked what I'd like and they have delivered it every day since. I've been asked if there's anything that needs to change and I know I only
have to pick the phone up and make a request and if it was possible it would happen." Another person said, Yes, the care is exactly what I've asked for. I have been quite specific of what needs and they've delivered."

People's needs were assessed and reviewed and people and their relatives said they were involved in these. People said the service was responsive to their changing needs and to any request they made. For example, one person said, "Yes. The care is very good indeed. If I asked them to change a routine they would do what they could to help and they would make a note of it on their machine that they carry with them."

Care plans included details of a range of people's needs such as personal care and domestic tasks, food preparation and more social needs such as hobbies and interests. Personal preferences were recorded. The specific details of what staff needed to complete for each care visit were recorded.
Care records were accessible to care workers, people and their relatives on an information technology system. People and their relatives could use this system to enter messages so care could be adjusted. In addition, there was a copy of a paper care plan at people's homes and people said they received a weekly schedule of the times and names of care workers who would be visiting them.

People were supported by care workers who knew them well and took the time to spend with people to reduce social isolation and loneliness. Details about community and social contact were recorded in a section called 'social inclusion' and care workers said they liked to spend time chatting to people and sometimes took people to the shops. Staff knew the importance of supporting people in the way they preferred. People said care workers spent time with them socialising which was important to them. For example, one person said, "They do anything I ask. I'm fairly unsteady on my feet. If they get everything done that I need and they still have time they will make me a cuppa and have a chat with me. When you're on your own it's good to know you have someone nice who you can trust coming in and they'll do what I ask."

We looked at the provider's complaints procedure. People said they knew what to do if they had a complaint. People said the care workers responded well if they raised a concern. The provider informed us there had been five complaints in the 12 months preceding the inspection. There was a record of each complaint made and the action taken to look into it as well as the outcome. This included a record of a response to the complainant. The provider's complaints procedure as set out in the Customer Guide supplied to people did not include details of the timescales the provider would respond to any complaint nor the details of who they should go to if they are not satisfied with how their complaint was handled, namely the government ombudsman or the local authority if applicable. This was rectified following the inspection.

The provider informed us that they had introduced an Equality and Diversity Impact Assessment which highlighted that the company was taking action to meet the protected characteristics of the Equality Act

2010 to ensure people were treated equally irrespective of age, disability, race, religious beliefs.

We looked at how the provider was meeting the requirements of the Accessible Information Standard (AIS) as required by the Health and Social Care Act 2012. This requires service providers to ensure those people with disability, impairment and/or sensory loss have information provided in an accessible format and are supported with communication. Care records included details about people's communication needs. The provider had a policy for people being able to access their records and for people who had communication needs which included reference to the AIS.

The provider had a Duty of Candour policy which is required by Regulation 20 of the Health and Social Care Act 2008 and outlines what providers must do when things go wrong and an apology when applicable.

At the time of the inspection there were no people in receipt of end of life care. The provider had plans to provide training in this for care workers with the intention of having a staff member who specialised in this as well as registering with the Gold Standard Framework in end of life care.

Good

Is the service well-led?

Our findings

Records were well maintained but there were discrepancies in care plans and records regarding the support people received with their medicines. Additional information was provided to us following the inspection which we were not made aware of at the time of the inspection despite discussions with the registered manager. This additional information clarified people were supported with their medicines. It was unclear why this information was not provided to us when we carried out the inspection. We also found an assessment regarding the risks of pressure injuries to one person was incorrectly completed as the score was not totalled and a medical need not included.

Notifications regarding any safeguarding concerns were made to the local authority. The Care Quality Commission were also notified of these with one exception, which was addressed and completed following the inspection.

The provider had plans to improve and develop the service and in 2016 had introduced an information technology system which enabled the agency management team to oversee the daily delivery of care to people. Care workers described the system as "working very well" and gave them ready access to information about people. This helped ensure the delivery of care to be people was monitored as it happened. The provider used a number of ways to assess, monitor and audit the quality and safety of the service.

People were asked to give their views on the service and the provider had strategies for involving people in decisions about their care and in the service, itself. There was a newsletter sent to people and care workers about current news about the service. The agency's management team had plans to increase the involvement of people with the service in formal and informal ways. People confirmed they were asked to give their views on the service they received as part of their care review which they said took account of what they said. Quality assurance surveys were sent to people to ask them for their views on the service and the results of these were displayed in the agency's office. The outcomes of the surveys were analysed and used for future planning. The provider's management team had a vision for the future direction of the service and looked for ways of how to continuously improve the service. The provider had plans to improve and develop the service and had recently introduced an information technology system which enabled the agency's management team to oversee the daily delivery of care to people. Care workers described the system as "working very well" and confirmed the system gave them ready access to information about people. The provider had a business continuity plan for the service.

Care workers described the management of the agency as supportive, open and approachable. For example, care workers said there had been issues with travel time impacting on the care schedule which they felt able to raise and was actioned. The provider also stated this had been addressed when care workers raised this and there was an action plan to improve this. Care workers also said regular staff meetings gave them an opportunity to discuss any problems and that these were acted on. The minutes of the staff meetings were displayed in the office. There was also a newsletter to staff with information about the service such as training courses. The agency supported staff to develop their skills and knowledge and

there was a Bluebird Care Career Pathway for staff.

The service had a registered manager who had completed a level 4 and 5 Diploma in health and social care management. The management team consisted of two care coordinators and two supervisors. Staff said there were good lines of communication for them to ask advice and that their views on people's care were listened to and acted on. The agency's management team were in turn supported by an operations director, who received weekly updates on new customers, staff supervision, care reviews and enquiries about possible care packages. This enabled them to monitor and improve the service. An internal audit completed by the provider scored the service 96.18 % as meeting the standards it measured. An audit by the local authority commissioners had also concluded the service met their standards.

Care workers described how they liaised with the community nursing team and a local hospice. There were links with the local authority safeguarding team and the commissioners. An external audit carried by the local authority commissioning team described the service as operating satisfactorily.