Select4 Limited

Bluebird Care (Calderdale & Bradford South)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service

Bluebird Care (Calderdale and Bradford South) is a domiciliary care service. It provides personal care to people living in their own homes in the community. The service supports people with a range of needs including people with dementia. At the time of this inspection there were 140 people using the service.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
Some people told us they experienced late and missed calls where the care worker did not arrive at all. They said they were happy with the care workers, but some people were not happy with the way the service was organised and managed.

People liked their care workers and said the quality of care was generally good. They received good support with their personal care, taking their medicines and with their meals. People and their relatives told us staff were kind and caring and did a good job.

Some relatives told us they were not happy with the communication from the service. They said it was at times hard to get through to the office on the telephone. The management team explained this was because office-based staff were having to go out to cover staff who were off sick so were not available to respond to phone calls.

The provider's systems for monitoring that care calls were taking place were not always effective. The monitoring system produced alerts for office- based staff when a care worker had not arrived at a customer's house to provide their care. However some alerts were missed due to the responsible person being out providing care and this had a negative impact on a few people who told us they had missed a meal and/or were upset by the missed call.

For several months the service had not been carrying out assessment visits to people before they started providing their care. This meant there were no environmental risk assessments for some people and other people had assessments and care plans which had not been updated for some time. The service relied on care workers to tell office based staff the risks they observed in a customer's home. The provider told us that this was improving at the time of the inspection.

Staff were happy working for this service. They said the registered manager and nominated individual (the person who represents the company) were responsive and helpful. The training was of a good standard but

the service was not up to date with the monitoring of care workers to ensure they were doing a good job.

The service had a comprehensive action plan in place to improve standards and the registered manager and nominated individual were very committed to improvement.

Rating at last inspection
The last rating for this service was good (published 01 May 2018).

Why we inspected
This inspection was prompted by a review of the information we held about this service. The inspection was prompted in part due to concerns received about staffing shortages having an impact on care. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe, responsive and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the well led key question section of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bluebird Care (Calderdale and Bradford South) on our website at www.cqc.org.uk.

Enforcement and recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified a breach of regulation in relation to the monitoring of care calls to ensure all required care is provided safely.

The provider has taken some action to address immediate concerns and also has a comprehensive action plan in place to improve the service.

We have made on recommendation to personalise emergency protocols for people who have diabetes.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

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Bluebird Care (Calderdale & Bradford South)

Detailed findings

Background to this inspection

The inspection
We carried out this performance review and assessment under Section 46 of the Health and Social Care Act 2008 (the Act). We checked whether the provider was meeting the legal requirements of the regulations associated with the Act and looked at the quality of the service to provide a rating.

Unlike our standard approach to assessing performance, we did not physically visit the office of the location. This is a new approach we have introduced to reviewing and assessing performance of some care at home providers. Instead of visiting the office location we use technology such as electronic file sharing and video or phone calls to engage with people using the service and staff.

Inspection team
This inspection was carried out by one inspector and one Expert by Experience who made telephone calls to people using the service and their relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

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

Notice of inspection
We gave four days' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be available to support the inspection.

Inspection activity started on 12 January 2022 and ended on 25 January 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included notifications, complaints, safeguarding alerts and feedback from local authorities and people using the service. We used information gathered as part of monitoring activity that took place on 21 December 2021 and 7 January 2022 to help plan the inspection and inform our judgements. We called 23 people who used the service or relatives of those who used the service as part of the monitoring activity to seek feedback on the quality of the service. There was negative feedback about timekeeping, missed calls and communication with the office which prompted this inspection.
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
This performance review and assessment was carried out without a visit to the location's office. We used technology such as telephone calls to enable us to engage with people using the service and staff, video calls with the management team and electronic file sharing to enable us to review documentation.

We spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with the registered manager and the quality assurance manager about the management of the service. We spoke with seven staff including two care coordinators, care plan assessor and four care workers. We also spoke with 18 people who used the service and/or their relatives.

We looked at the care records for ten people who used the service. This included risk assessments, care plans, records of their care calls over two weeks and medicines records. We also looked at staff training records, recruitment records for three staff, complaints and records related to the management and quality monitoring of the service.

After the inspection
We continued to seek clarification from the registered manager and nominated individual to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

- The service had been experiencing staffing challenges for several months including recruitment, staff retention and staff sickness due to the COVID-19 pandemic. The management team were working to an action plan and working hard to minimise impact on people using the service. They told us they now had enough staff employed but sickness was a current challenge.
- Some people and their relatives told us that they had experienced missed calls where the care worker did not arrive which impacted negatively on some people.
- An electronic call monitoring system was in place. This was used to monitor people's care calls in real time and ensure that care staff arrived at their calls on time and that calls were not missed. However, the systems and processes in place were not always working effectively. This is a breach of Regulation 17 of the Health and Social Act (Regulated Activities) Regulations 2014. This is addressed in the well-led section of this report.
- People were generally satisfied their care was provided on time and for the right amount of time.
- Staff were recruited following safe practices to minimise the risk of unsuitable people being employed.
- The recruitment process included an application form, criminal record checks, evidence of conduct in previous employment, right to work in the UK and proof of identity.
- Staff completed an induction of mandatory training and working alongside more experienced care workers until they were competent and confident to work alone. They said the quality of the training provided by the service was good and ensured they could deliver safe care. One care worker told us, "There is absolutely tons of training."

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks associated with people's health and care needs were not consistently assessed.
- The provider had informed us that due to staffing shortages they had not been able to carry out initial visits to new customers to carry out environmental risk assessments and their own assessment of the person's needs. They used the care plan provided by the referring local authority and then care workers updated the management team about any new or changed needs their customers had.
- The provider assured us that every new customer from 4 January 2022 would have a risk assessment and care plan carried out face to face but they had not yet taken any new people since that date.
- There was no evidence of harm to people from the lack of risk assessment by the service but there was a

potential risk of harm.
● The risks assessed in people's files included risks associated with falls, skin integrity, moving and handling.
● Emergency protocols in place for people with diabetes were generic rather than specific guidance for the person.

We recommend that diabetic protocols are reviewed to meet individual needs.

● All accidents and incidents were reported and recorded with details of the accident/incident, immediate actions taken, the outcome and any follow up actions to be taken.
● When an incident occurred such as a missed call or accident the service's quality assurance manager investigated the circumstances and the management implemented changes to try and ensure the same type of incident would not reoccur.

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risk of abuse.
● The service reported any safeguarding concerns promptly to the local authority in line with required safeguarding procedures and also notified CQC.
● Staff had completed safeguarding training and told us they would report any concerns to the manager without delay. We saw examples of where care workers had done this and safeguarding alerts were appropriately raised.
● The registered manager demonstrated a good understanding of safeguarding and the actions to take to report all concerns.
● Where concerns had been raised about the conduct of a care worker these had been addressed and appropriate action taken. People were able to request that any care worker they did not like was removed from providing their care. We saw that these requests were met in all cases.

Using medicines safely
● People received their medicines safely and as prescribed.
● People's support needs in relation to medicine administration were documented in their care plan including the names of medicines prescribed, how and when they should be administered.
● The electronic care record monitoring system in place enabled the service to monitor and ensure people received their medicines on time. If a care worker did not record that they had given a person their medicine, the system would send an alert so that senior staff could check the reason.
● Medicine administration records were completed well by staff. They were monitored on a monthly basis by a designated person.
● Care workers completed medicines training and their competence was assessed to ensure they had understood their training and were able to administer medicines safely. Staff told us they were happy with the training they received and felt confident supporting people with medicines.
● People told us they received the right support from their care workers with their medicines. Comments included: "No issues with medication", "Yes they do that OK" and, "Yes they give her tablets."

Preventing and controlling infection
● Systems and processes were in place to ensure people and staff remained safe and protected from the spread of infection.
● Care workers told us they always had a good supply of personal protective equipment (PPE) which included gloves, masks and aprons. People confirmed that their care workers wore the required PPE when heling them with their care.
● Staff followed the current required testing regime for COVID-19 and the service monitored this to ensure

staff did not work when unwell.

● Care workers told us their training on COVID-19, infection control and the correct use of PPE was comprehensive. The training included practical demonstrations of how to don and doff PPE safely.

● Care plans included prompts to staff to put on new PPE and how to dispose of PPE and care workers had to record that they had completed this task. Care plans also contained guidance on how to safely handle soiled bedding, empty commodes and other tasks where there was potential risk of infection.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. The rating for this key question has remained good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People received personalised care and support.
- Care plans detailed people's health and care needs as well as their likes and dislikes. Some care plans were very good and included a level of detail to enable a new care worker to meet the person's needs well. For example, one care plan detailed where to find each item the person needed for personal care, others had comprehensive details about the person's individual meal and drink requirements.
- Although there was a backlog on reviewing care plans the service had employed a person to work full time on writing new care plans and updating old care plans. This process had just started at the time of the inspection.
- Records of care provided by care workers were generally of a good standard which showed evidence of completing all the required care tasks and some were very detailed about the person's health and wellbeing which gave a good picture of how the person was in a person centred way.
- People and relatives told us that they were generally satisfied with the quality of care provided by their care workers. Comments included; "I think the people give mum good care," "They do the job," Yes, the carers work really hard to make sure mum has the care she needs" and, "They are fairly efficient at the job."
- Care workers knew their customers well and demonstrated a good understanding of person centred care when we discussed people's care plans with them.
- Care workers shared information in a staff WhatsApp group to help ensure people received personalised care. In this way, care workers in the morning could pass on information to the afternoon care workers , for example to hang out a person's washing or to buy them a pint of milk on the way to the call.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Where people had specific communication needs and preferences this was recorded in their care plan. For some people their favourite topics of conversation were recorded to encourage are workers to engage meaningfully with them during their care visits.
- Some people's care plan included chatting to the person as a care task that the care worker was required to tick as completed and to comment that they had chatted with their customer. This helped the service to ensure care workers understood the importance of communication and also helped the service monitor whether they were doing so. Care records showed staff recording comments such as "Had a lovely chat."
- Staff were aware of people's communication needs.

● One relative said, "The carers are really good they will sit and chat with mum." Another told us, "The lady and guys are caring and they have a joke with (person) even though he has no speech. They engage with him." A third relative said, "You can see they are having a good chat."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● The service supported people with their interests and social activities where this was an assessed need.
● Some people had care visits that were for companionship and to reduce social isolation.
● The nominated individual told us about social opportunities they had initiated which people could participate in before the national lockdown and would be able to in the future.

Improving care quality in response to complaints or concerns

● Policies and processes were in place to respond to complaints.
● Some relatives told us they had complained or raised concerns and felt their concerns had been dealt with properly and they had seen improvement in the service after complaining. People said they knew how to make a complaint if they needed to and who to call if their care worker did not arrive.
● Relatives knew who to speak with if they had any concerns.

End of life care and support

● Staff had completed training in providing care to people at the end of life.
● Staff told us they felt confident in providing care to people at the end of their life.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement.

This meant the service management and leadership was inconsistent. The governance systems in place did not always effectively ensure safe person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The management team had clear designated roles and office based staff roles changed in order to meet changing priorities. There were roles which were designated for checking the call monitoring system including a small team of out of hours staff who worked early mornings, evenings and weekends to deal with any issues. These staff were also trained in care and at times would go out to provide care when there were unexpected staff shortages. When the out of hours worker was our providing care one of the management team would cover monitoring the system to check for any alerts such as care worker not turning up or a call.
● Despite there being an electronic system in place to monitor calls this was not consistently effective in ensuring people received their care safely. People told us of missed calls, sometimes where nobody had told them the care worker would not be coming. This had a negative impact on the person who was upset and some had missed a meal.
● One relative told us, "….. my mum didn't have food for 8 hours. They said we cancelled a call. I know I did not. My mother is not able to call them." Records confirmed this was accurate. Another person said, "No one came for my tea call at 4.30pm, I waited no one came at 5.30 or 6.30pm. They came for my last call at 8pm. Luckily my neighbour made me tea, or I would not have eaten." This was a missed call the management team had not been aware of.
● The management team looked into the missed calls reported to us during the inspection and were able to explain what had happened but there were a few missed calls people had told us about and they had not been aware of which was evidence that the systems and processes in place were not working effectively. Nine of the eighteen people we called told us they had experienced a missed call at some point with only one being told in advance that no care worker was available to come. Records showed in January 2022 a third of the missed calls were situations where a care worker did not turn up and the person was not informed. The others were when the service cancelled the call and told the person they could not come. In January 2022 the service started recording the missed calls and who authorised the call to be cancelled due to staff shortages.
●There was no alert raised in the electronic monitoring system if a care worker did not stay for the agreed time for the call. When we checked a sample of ten people's care call durations on over two weeks we found examples of unexplained shorter calls. There was a system in place where a designated staff member

checked care records but this had not noted some of the short calls we found. It also did not highlight patterns where specific care workers stayed less time than others which could potentially be a concern to follow up. It was also possible for staff to log in outside of the electronic system which was open to abuse as this could be done from anywhere. Where we found one example of this we were assured that the management team had been informed and addressed it promptly and appropriately.

● Due to the staffing problems the service had been experiencing, monitoring of the quality of care provided was not taking place regularly. Some staff had not received regular supervision. Spot checks on care workers in people's homes to ensure they were working to required standards had not been taking place. Telephone calls to people using the service and relatives to check if they were satisfied with the service had stopped. The lack of these processes in place meant there was a risk that some people were not happy with the care they were receiving.

● Although we recognise that staffing issues had led to these monitoring checks not being carried out and the management team had been open and transparent in telling us about this, it was clear that overall satisfaction with this service had decreased in recent months.

● A customer survey from May 2021 showed very positive feedback about the service. The feedback we received as part of this inspection was positive about care workers providing good care but less positive about the service as a whole and the way it was run.

● People using the service and their relatives said that they found it hard to communicate with office based/management staff as sometimes the phone in the office would ring out and wouldn't be answered and that emails to the office were not always replied to. Comments included; "I have tried to ring in last two or three days and no one picks up or gets back to me. I left my phone number" and, "I ring them, I have rung them in the morning to try and find out what time the call is going to be and they don't answer."

● The nominated individual told us when office based staff had to go out in emergencies to provide care that there could at times be nobody answering the phone. Some people did not know who the registered manager was and believed they had complained to the manager when it was an administrative officer. They said they did not always get a call back when they had raised a concern and did not always get an explanation for a missed call.

● Routine risk assessments when starting to provide care to a new customer had stopped months previously due to staffing problems. The service relied on information provided by the local authority and by the care workers who started providing care. This carried the risk that a reliance of on care workers to identify risks meant that there was a possibility that some safety risks may not be identified. The provider assured us the assessments were starting again but there had been a long period where they did not take place. This left people at risk of their needs not being correctly identified.

The above amounts to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Prior to the inspection the provider told us there was no audit trail for when an agreement had been made to cancel a care call or cut the call short or to send one worker when the person required two workers. From 4 January 2022 the provider set up a spreadsheet to record these decisions and have an audit trail.

● Safeguarding concerns, complaints and accidents/incidents were dealt with a designated quality assurance manager.

Continuous learning and improving care; Working in partnership with others

● The nominated individual and the registered manager were very committed to continuous learning and development to continually improve the quality of the service.

● The service had an improvement plan which they updated regularly. The nominated individual was very aware of the service's shortfalls, was open and transparent and worked hard to make regular changes to

work on different areas of improvement, for example employing staff to work full time on care plans.
● The local authorities working with this service told us the service was engaging well with their monitoring processes. One authority said that the service sent them regular updates on their improvement plan and followed advice from them. They said they thought they were a good provider who tried their best throughout the pandemic and the pressures this brought.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The service promoted an open, inclusive culture.
● In our meetings with the registered manager and nominated individual we found them to be extremely open and committed to improving outcomes for people.
● Care workers also gave very positive feedback about the registered manager and nominated individual. They told us they were happy working for this service. They said the registered manager and nominated individual were approachable and supportive. One person said about the nominated individual that they "could not praise him enough" and another said about the registered manager, "She is very approachable and very involved." Staff felt well supported.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The nominated individual and the registered manager both understood their legal responsibilities in relation to being open and honest with people when something went wrong. Records confirmed this.
● One person said the service apologised to them, "The odd time when they have missed calls or been very late. They always apologise."
● They also had good understanding of their responsibility of informing CQC and other involved agencies where specific incidents had taken place or allegations of abuse had been made.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and process in place to assess, monitor and improve quality and safety of service provided were not sufficiently effective.