ENM Limited

# Bluebird Care Birmingham North

## Inspection report

Enterprise House, 656 Chester Road
Erdington
Birmingham
West Midlands
B23 5TE

Date of inspection visit:
08 January 2019

Date of publication:
26 March 2019

## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

People's experience of using this service:
People told us they felt safe using the service but we found that calls to people had been missed. This meant people had on these occasions missed meals and their medication. People did not receive their medication at the right time on a consistent basis. People were not protected from harm because risk assessments had not been completed and not all staff had gone through thorough recruitment procedures to ensure they were suitable to work with vulnerable people.

Records of incidents and accidents were not kept so no action was taken to reduce the risk of re-occurrence and audits and checks were ineffective in highlighting where practice needed to be

improved to reduce the risks to people. Staff had not received sufficient training or supervision to ensure they could deliver safe and effective care.

Several experienced staff who knew people well had recently left the service and people and their relatives were concerned about how the service was being led and managed. Staff did not feel they were listened when they raised concerns or complaints and did not feel valued. People and their relatives were not routinely involved in developing the service and there were no quality plans in place to drive quality improvement.

It was unclear whether people had agreed or consented to receive treatment or had contributed to the development of their care plans. People were supported to access health care services when they needed to and people and their relatives told us that staff were good at monitoring their health needs.

Staff treated people with kindness and respect, but sometimes felt staff were rushing to finish their care as quickly as possible. People and their relatives knew how to complain but did not feel confident that their concerns would be listened to or acted on.

The franchise owner had undertaken a recent quality audit which had identified similar areas of concern that were found at this inspection. Work had started in a few areas on addressing these concerns but improvements were not yet established or having an impact on the quality of the service.

About the service:
Bluebird Care Birmingham North is a domiciliary care service which is registered to provide personal care to people living in their own homes. At the time of inspection, 17 people were receiving care and support services.

Rating at last inspection:
This was the first time we had inspected this service.

Why we inspected:
This was a planned inspection, which took place on 08 January 2018.

Follow up:
As we have rated the service as inadequate, the service will be placed in 'special measures'. Services in special measures will be kept under review and, if we have not already taken immediate action to propose to cancel the provider's registration of the service, it will be inspected again within six months.
The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe, so that there is still a rating of inadequate for any key question or overall, we will act in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.
For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.
Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

| | |
|---|---|
| **Is the service safe?**<br>The service was not safe.<br>Details are in our Safe findings below. | **Inadequate** |
| **Is the service effective?**<br>The service was not always effective.<br>Details are in our Effective findings below. | **Requires Improvement** |
| **Is the service caring?**<br>The service was not always caring.<br>Details are in our Caring findings below. | **Requires Improvement** |
| **Is the service responsive?**<br>The service was not always responsive.<br>Details are in our Responsive findings below. | **Requires Improvement** |
| **Is the service well-led?**<br>The service was not well-led.<br>Details are in our Well-led findings below. | **Inadequate** |

# Bluebird Care Birmingham North

**Detailed findings**

## Background to this inspection

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

Inspection team:
Two inspectors conducted the inspection.

Service and service type:
Bluebird Care Birmingham North is a domiciliary care service.

The registered manager had left the service and a new manager had been appointed in August 2018 but had not registered with CQC. For this report, they will be referred to as the 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.

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

What we did:
Prior to the inspection we reviewed any notifications we had received from the service. A notification is

information about important events which the service is required to tell us about by law. We also reviewed any information about the service that we had received from external agencies. We used this information to help us decide what areas to focus on during our inspection.

Before the inspection we conducted telephone interviews with one person and three relatives to ask them about their experiences of using the service.

During the inspection, we visited the office location on 08 January 2019 to see the manager and staff; and to review care records and policies and procedures. We spoke with five care staff, the manager, the operations manager, the provider and with two people and three relatives. We reviewed three people's care records, four staff files around staff recruitment, training and supervision. Records relating to the management of the service and a variety of policies and procedures developed and implemented by the provider were also reviewed.

Inadequate

# Is the service safe?

## Our findings

Safe – this means people were protected from abuse and avoidable harm

People were not safe and not protected from avoidable harm. Some regulations were not met.

Safeguarding systems and processes:
• Most people and their relatives thought the service kept people safe. One relative told us, "The service has a really good reliable system in place which means [person's name] is safe." However, some relatives were concerned that calls to their family members had been missed which meant people had missed meals or medication. We looked at records which showed that several calls had been missed. There had been at least three missed calls since August 2018.
• The failure to ensure all care calls were made exposed to people using the service to the risk of harm and was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
• One relative told us that their family member, who was living with dementia, had a key code on their front door to allow staff to let themselves in. The provider had agreed to let the family know when new staff started so that they could change the code to ensure only current staff could enter the house. This had not happened.
• Staff had not received safeguarding training. However, staff were aware of who to report safeguarding concerns to and felt confident that their concerns would be acted on.

Assessing risk, safety monitoring and management:
• Whilst some risk assessments had been completed, the risks to people because of their disability or condition had not been assessed. We saw that one person's moving and handling risk assessment had not been completed. This meant staff were not aware of how to manage and reduce the risks to people.
• The failure to ensure risks relating to the safety and welfare of people using the service are assessed and managed was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely:
• People did not receive their medication on a consistent basis. We looked at medication records which showed that doses had been missed and the manager and provider could provide no explanations to why this was the case.
• Records showed that one person had not received their medication due to a call being missed. Other medication records were blank when people had gone to visit relatives but it was not clear from the records which days these visits had occurred. The provider could therefore not provide any assurances whether medication had not been missed.
• Some people required to take medication 'as and when required'. There were no protocols or guidance for staff as to when these medicines should be given or offered. This meant people were not receiving these medicines on a consistent basis. We asked the provider about this and they acknowledged protocols were not in place.

• Some people required creams to be applied to parts of their body but there were no body maps to guide staff to where these creams should be applied. The provider acknowledged that these were not in place.
• The failure to protect people from the risks associated with the unsafe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

Learning lessons when things go wrong:
• The provider had no system to record accidents and incidents. No analysis of accidents and incidents had not taken place, so themes and patterns had not been identified or monitored. Investigations had not taken place following incidents to ensure lessons were learnt. This meant the risk of harm or incidents reoccurring were not being reduced.
• For example, we saw that there had been several missed calls to people. No investigation of these incidents had taken place and measures had not been implemented to reduce the likelihood of this happening again.

Staffing levels:
• Recruitment practices were not always safe. This meant people were exposed to the risk of being supported by staff who were not suitable. For example, one member of staff had started work without a Disclosure and Barring Service (DBS) check. The DBS service allows providers to check people's suitability to work with vulnerable people.
• A member of staff had been employed as a 'bank' staff which means they were asked to work on an occasional basis. The provider had undertaken some pre-employment checks on this member of staff but could not provide any evidence of references, interview notes or pay slips which could prove they were an employee of the service.
• Care staff were interviewed by the operations manager who had no experience of the care sector. The operations manager told us they felt uncomfortable making decisions about potential staff's suitability to work for the service given.
• The failure to ensure staff were suitable to work with adults at risk was a breach Regulation 19 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.
• People, relatives and staff told us they were concerned about the number of staff that had left the service. Although there was no evidence that there were not enough staff to cover calls, people told us that they often did not know who was coming to see them. One relative was concerned that their family member was being affected by so many staff changes. They told us, "[Person's name] has had six different carers this week. They have dementia so this is a problem". The manager told us that they had to spend a lot of their time covering calls which was taking them away from their management duties.
• People and staff told us that there was enough time to complete all the care and support required in the times allocated.

Preventing and controlling infection:
• There were no infection control audits in place. When we discussed this with the manager they told us they had planned to introduce this soon.
• Staff were preparing food for people but had not received food hygiene training. This meant that staff did not have the knowledge of how to keep safe from unsafe practices.
• Staff told us that they used gloves and aprons when delivering personal care. One member of staff told that this equipment was not always available to them as the provider had not ordered sufficient supplies. This meant that staff had had to purchase their own gloves and aprons on occasions.
• People and relatives told us that staff left people's homes clean and tidy at the end of each call.

Requires Improvement

# Is the service effective?

## Our findings

Effective – this means that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Staff skills, knowledge and experience:
• People and relatives provided a mixed view about the skills of the staff. One person told us, "The staff know what they are doing when they come to see me." One relative told us, "I have a few issues with the new carers as no-one seems to know what they are doing."
• Staff told us they did not receive regular training or updates to keep themselves up to date. One member of staff said, "I have never had any training since I have been here." Records showed that very little training had been completed by staff in the last 12 months. We raised these concerns with the manager who acknowledged that training was an issue. The provider told us that they had just registered with a new online training company which would enable staff to complete more regular training but this had not yet started at the time of our inspection.
• Staff were given face to face training on handling medication and moving and handling in the provider's offices. However, the in-house trainer told us that the training facilities and equipment were poor and did not enable adequate training to be given. For example, the training room was too small and the bed was too low to deliver proper training. The trainer told us staff were therefore moving people without the required knowledge and training. The trainer also told us that this had been raised with the provider but no action had been taken.
• Most of training that had been provided for staff was through the completion of work books. We saw that staff completed these but their responses were not checked so the provider could not be assured staff had understood the training. We saw that staff required further training because some of their responses in the work books were incorrect. Staff had also asked for further help or training in their work books but this had not been provided.
• New staff received an induction and were given an opportunity to shadow more experienced staff. One person told us, "One lady has just started caring for me and she has been out with an experienced carer. The trainer is doing an excellent job." However, staff told us that shadowing opportunities were reducing because the more experienced staff were leaving the service.
• Staff had not received regular supervision or had an annual appraisal. One member of staff said, "I have never had any supervision and staff rarely get supervision due to calls having to be done." This meant staff did not have the opportunity to reflect on their practice and develop their skills.

Ensuring consent to care and treatment in line with law and guidance:
• 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 as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as

possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.
• We found the service was not consistently working within the principles of the MCA. For example, some people being supported lacked the capacity to consent to their treatment and therefore their care plans and risk assessments had been signed by their relatives to indicate their consent. However, there was no evidence that these relatives had the legal right to do this. For example, one person's care plan had been signed by their spouse but there was no evidence that there was a Power of Attorney (PoA) in place. Records indicated that some relatives had PoA but there no copies of these for staff to check who could consent of behalf of their family members. We asked the provider about this and they acknowledged that they needed to ensure copies of the PoA forms were obtained.

Staff providing consistent, effective, timely care:
• The feedback from people and relatives regarding consistent and timely care was mixed. Some people were very happy with the service but others told us that calls were often late and they were not always informed. This had an impact on people's routines and dignity. One relative told us, I'm not always told when they are going to be late and I have to hang about and can't go out." Another relative told us that their family member was often waiting for personal care in the mornings, so delays were difficult for them.
• Some people were also concerned about the lack of consistency because so many staff had left and they were always seeing new faces. This meant people had not always had the chance to develop good relationships with staff and staff did not always know people's needs well. One relative told us, "I'm not told when carers have left and all the regular carers have gone."

Eating, drinking, balanced diet:
• Some people told us they required support to prepare food and drinks and prompts to ensure they maintained a healthy diet. People and relatives told us that some staff were good at making sure people had enough to eat and drink. One person told us how staff always made them a cup of tea before they left. One relative told us, "The staff know my Mum has to have extra drinks due to her blood pressure and they make sure she does."
• However, other relatives were not as positive with their feedback. One relative told us how staff did not follow the care plan for their family member. They said, "They leave lunch in the kitchen but it should be left on the table as [person's name] does not know to look in the kitchen."

Supporting people to have live healthier lives, access healthcare services and support:
• People and relatives told us that staff helped them to access healthcare services and monitored their health needs. One relative told us how staff had helped their family member. They told us, "[Person's name] had some bed sores from a recent stay in hospital but they have gone now and staff have helped by putting the right barrier creams on."
• Another relative told us how well staff had managed recent incidents when their family member had experienced a series of falls. They said, "The staff dealt with the incidents and the emergency services really well."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• People's needs were assessed prior to moving into the service and records showed that care plans were reviewed regularly or when people's needs changed.

Requires Improvement

# Is the service caring?

## Our findings

Caring – this means that the service involved people and treated them with compassion, kindness, dignity and respect.

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported:
• People and relatives were positive about the staff and said they were treated with kindness. One relative told us, "The carers are good and kind – they are very friendly and chatty." Another told us, "[Person's name] can be quite awkward at times and they [the staff] handle it really well." Other people told us that staff were happy to "go the extra mile" and help with washing and changing light bulbs when needed. However, despite people's positive comments about the staff team, we identified areas of practice which were not consistently caring. The provider had not ensured people were adequately supported in terms of protecting their safety, ensuring that medicines were managed safely and ensuring people were supported by consistent, well trained staff. There had also been occasions where calls to people had been missed. These concerns are covered elsewhere in the report.
• Some people told us that they felt rushed by some carers who did not stay for the full time allocated. One person said, "One carer doesn't make the bed or wash me properly; she is always in a hurry. Staff rush me because I'm one of the easy ones".
• People and relatives expressed their concerns that staff who had got to know them well had now left. One person said, "I feel very vulnerable because the carers who made me feel they were interested in me are now leaving."

Supporting people to express their views and be involved in making decisions about their care:
• There was no evidence to suggest that people had been supported to express their views. One person said, "I haven't told anyone about my concerns because I feel vulnerable."
• People told us they were not actively supported to be involved in decisions about their care. There was no evidence in care records that people had been involved in decisions about their care. For example, people had not signed their care plans and there was no evidence of people or relatives being involved in any review meetings.

Respecting and promoting people's privacy, dignity and independence:
• People and relatives told us that some staff helped people to retain and improve their independence. One relative told us, "[Person's name] has had some really good carers and they are helping her to mobilise during the day more now."
• People and staff told us people were treated with respect. One person told us "I am treated with respect and they are all very kind".

Requires Improvement

# Is the service responsive?

## Our findings

Responsive – this means that services met people's needs

People's needs were not always met. Regulations may or may not have been met.

Personalised care:
• There was no evidence that people were consistently empowered to make choices or have as much control and independence as possible, including developing their care and support plans. One relative told us how staff often called too early in the evening and that their family member did not want to go to bed at that time.
• People and their relatives told us that care plans were not always followed. One relative told us, "I have issues with the new carers as no-one knows what they are doing and the care plan is out of date." One member of staff told us that they had been sent out to a new customer without any care plan. They said, "I had no information and found the person used a hoist and had diabetes but I knew nothing about this."
• We saw that care plans were reviewed by the staff team every six months but there was no evidence of how this process involved or was communicated to people or their relatives. One relative told us, "There was a review meeting on 09 November 2018 but we have still not had the new care plan."
• One relative told us how responsive staff were to their requests to come at specific times which allowed their family member to go out for the day or visit friends. Another told us how staff had developed a communication system using white boards which helped them communicate with one person who was partially deaf.

Improving care quality in response to complaints or concerns:
• People and relatives knew how to complain but were not all confident that their concerns would be listened to or acted on.
• We viewed the complaints file and saw that a new complaints policy and procedure had recently been introduced. This meant that two recent complaints had been promptly acknowledged and were currently being investigated. Previous complaints had not been properly recorded or investigated and there was no clear evidence of how complaints had been responded to. We saw that there was no system in place to see how people's concerns had been addressed or to understand any emerging themes or patterns of people's concerns.
• The provider had received five compliments in the last 12 months from family members, praising the caring attitude and nature of the staff team.

End of life care and support:
• People had end of life care plans in place which outlined their future wishes. No-one was receiving end of life care at the time of the inspection.

Inadequate

# Is the service well-led?

## Our findings

Well-Led – this means that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements:
• At this inspection we found the quality assurance processes continued to be ineffective and did not pick up on the issues identified at inspection. These included concerns with recruitment, staff training, risk management and medicines and details can be found earlier in this report.
• Numerous concerns were identified with records. These included incomplete, inaccurate risk assessments, gaps in medicine records and lack of incident and accident records. There was a risk that if robust records were not put in place, this could negatively impact on people's health, safety and well-being.
• A failure to have effective systems and processes in place to monitor and mitigate risks to people was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
• The manager had been in post since August 2018 but had not registered with CQC. The service is required to have a registered manager in place and there had been a delay in complying with this.

Continuous learning and improving care:
• Despite a recent quality audit from the franchise company, there was no improvement plan in place. The manager confirmed that improvement in the service had been slow and felt they did not have time to implement improvements. We saw that some new processes were being introduced, such as a new complaints policy and procedure, but there had been no progress in many areas.
• Incidents did not prompt learning to improve care. For example, we saw that there had been missed calls to people. There was no evidence that these had been followed up or that the provider had learnt from these incidents to improve care for people. There was an electronic system in place to log calls but this system was not being used to monitor punctuality or the length of calls or to identify trends.
• There were no actions identified in the audits that were in place which meant improvements could not be made.
• A failure to have effective systems and processes in place to monitor the quality of the service was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff; working in partnership with others:
• There were no records that demonstrated people or their relatives had been involved in decisions about their care or the running of the service. Surveys to gain feedback about the service had been sent out but had not been analysed. One relative said, "We do fill out questionnaires but nothing happens."
• Staff told us that they did not feel listened to by the provider. For example, a group of staff had submitted a joint complaint in October 2018 but they had received no acknowledgment or response to their concerns. One member of staff told us, "The managers don't listen to us when we have concerns." One member of staff

told us that the provider had told them not to listen to any problems the staff raised.
• A team from the franchise company was helping to improve the quality and safety of the service provided to people. The provider told us that they valued this support.

Plan to promote person-centred, high-quality care and good outcomes for people:
• Person-centred care was not promoted in the service and people did not always receive high quality care. This has been demonstrated in the other domains of this report.
• The service was not open or transparent. For example, information had not been given to people or relatives regarding care plans, rotas or staff leaving.
• Staff demonstrated commitment to the people they were supporting and told us they wanted to provide good quality care to the people. The provider told us they were determined to make improvements to the service so people experienced a good quality service.

This section is primarily information for the provider

# Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Calls were being missed which meant people had missed meals and medication.<br>Risk assessments were not completed in relation to people's conditions.<br>Medication records did not indicate people were receiving their medication at the right time. |

**The enforcement action we took:**

Urgent notice imposing a condition to restrict new care packages and provider meeting.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Audits were ineffective and had not identified issues highlighted at this inspection.<br>The quality of the service was not being monitored to ensure people received a safe and effective service, |

**The enforcement action we took:**

Urgent notice imposing a condition to restrict new customers and a provider meeting.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>Employment checks to ensure staff's suitability to work with people were not robust. |

**The enforcement action we took:**

Urgent notice imposing a condition to restrict new care packages and a provider meeting.