Anndrew Ltd

Bluebird Care

Inspection report

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15 May 2019

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: Bluebird Care is a domiciliary care agency that was providing personal care to 36 people in their own home at the time of our inspection.

People's experience of using this service:

Quality monitoring systems were not effective to ensure people received safe care. The registered manager's ability to develop systems to provide oversight of the service had been limited by a lack of support. The provider had limited formal engagement with people, staff and other services.

There were insufficient numbers of staff leading to people not always getting the whole provision of care planned. Risks to people's health and wellbeing were not always effectively identified, assessed or mitigated to protect people from the risk of abuse.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; the policies and systems in the service did not support this practice. The provider did not always respect people's right to make decisions about their health and wellbeing. Staff training and supervision was not effective to meet the needs of people. People's needs and choices were not planned and reviewed consistently to achieve best outcomes. The provider did not always work with other agencies to support people to have the best possible health outcomes.

People's privacy was not always respected because the provider did not always allow enough time for staff to support people.

People felt they were receiving their medicines as prescribed; however, medicine records did not always reflect when people received their medicines.

People's end of life care needs were not assessed and reviewed. People were not always involved in planning their care and did not always receive care that met their needs. Complaints and concerns were not always investigated thoroughly to be able to improve practice.

Care staff were kind and respectful and respected people's independence.

Practices were in place to ensure the prevention and control of infection protected people.

People were able to exercise choice and felt they received the support they needed with their meals.
Rating at last inspection: This was the first inspection for Bluebird Care. The service was registered on 22 June 2018.

Why we inspected: This was a planned inspection brought forward due to information of concern.

Enforcement: There are six breaches in regulatory requirements. You can see the action we asked the provider to take at the end of the report.

Follow up: The overall rating for this service is 'Inadequate' as this is the second consecutive occasion that the service has been rated inadequate in well led and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Bluebird Care

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) 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 Act, 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 carried out the inspection.

Service and service type:
Bluebird Care is a domiciliary care agency, it provides personal care to people living in their own homes in the community. The service supports younger adults and older people living in their own homes. At the time of this inspection 36 people were using the service.

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 the service four days' notice of the inspection site visit to ensure people consented to receiving a home visit or telephone call from us.

Inspection site visit activity started on 14 May 2019 and ended on 16 May 2019. We visited the office location on 15 May 2019 to see the registered manager and office staff; and to review care records and policies and procedures.

What we did:
We used information we held about the home which included notifications that they sent us to plan this inspection. We also received information from professionals involved with monitoring the home. On this occasion we did not ask the provider to complete a Provider Information Return (PIR). 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. Therefore, we gave opportunities for them to update us throughout the inspection.

We used a range of different methods to help us understand people's experiences. On 14 May 2019, we visited three people in their own homes. We also spoke with two relatives during these visits. We spoke with two people and three relatives on the phone to gain their feedback. On 15 May 2019, we visited the office and spoke with the registered manager, two deputy managers and the recruitment manager. We also spoke with two care staff. On 16 May 2019, we spoke with two more care staff on the telephone to gain their feedback. Prior to the inspection, we had spoken with the local authority and read the report from their recent visit.
We reviewed care plans for five people to check they were accurate and up to date. We also looked at medicines administration records and reviewed systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement. These included meetings minutes and quality audits.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Staffing and recruitment
• There were insufficient numbers of staff leading to people not getting the whole provision of care planned.
• We saw this impacted on care for one person who required two members of staff for their care. On the day of our home visits, we saw the staff arrived twenty-five minutes apart and one member of staff had to wait outside. A relative told us, "It is supposed to be two staff each time but often only a single carer comes, and I am asked to help. There aren't enough staff. I'm getting ill from helping." This put the person at risk of harm and there was no risk assessment in place to mitigate the risk of them helping with care. When we reviewed daily care records, these were not clear as to how many staff attended the calls for this person.
• People felt that they did not always receive their care at the right time. One person told us, "Timekeeping is not good, the staff tend to be late each time." A relative told us, "Timekeeping varies, they are often late, and I have had to cancel some calls as it was too late and impacting on [Name's] sleep." Another relative told us, "We have had a couple of times when the morning call has been so late that the staff arrive at the same time as the lunchtime call."
• We reviewed rotas and the call system which showed calls were often started late or finished early.
• There had been a high turnover with staff and one relative told us, "There is a large turnover and it seems a bit chaotic. That is worrying for the elderly, not having that familiar face."
• The provider used agency staff to cover absences, but these were not supervised by effectively trained staff to ensure safe and effective practice.

This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• People told us they felt safe, but this contrasted with our findings. We found people were not always protected from potential harm.
• Risks to people's health and wellbeing were not always effectively identified, assessed or mitigated.
• For example, one person was at high risk of falls with a history of falling. A risk assessment of this falls risk had not been done to be able to mitigate this risk.
• Another person required equipment when getting out of bed but the risk assessment in place was not up to date to reflect the current equipment used.
• There was no analysis of incidents, such as falls, for staff to be able to learn lessons.
• We asked staff to provide us with this type of analysis and none could be evidenced.
• We asked staff to demonstrate how they monitored missed or late calls, the office staff were not clear on how to use the system to show us this. We were then told missed calls were not monitored or analysed.

• One person felt this left them feeling vulnerable and told us, "Sometimes I haven't had any attention for hours and what if I'd fallen?"
• This left people at risk of harm from not receiving the care they require to keep them safe.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
• People were not always protected from risk of abuse.
• Although staff had received safeguarding training the provider had not ensured that systems were in place and followed to ensure safeguarding concerns were reported to the local authority safeguarding team and to us as required.
• Staff were able to tell us what constituted abuse, however we found evidence of at least two incidents which had not been referred to the local authority safeguarding team for investigation.
• The registered manager and staff told us about a medicines error that occurred when a relative was responsible for medicines. Although the provider had acted to mitigate this risk, they had not appropriately referred this to the local authority or notified us.
• Staff told us about an occasion where one person was not at their house and the door was unlocked. This person was vulnerable due to their health conditions, but some staff had not recognised this as a risk and therefore not referred this incident to the safeguarding team or reviewed this person's care.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
• People were mostly receiving their medicines as prescribed. One person told us, "They do my medicines, they fill in the chart and put it in front of me. They always sign the chart." However, we saw medicines records were not always completed accurately to record what medicines people received and when. Systems were not in place to identify any errors promptly to ensure medical advice could be sought.
• Staff understood their responsibilities to ensure safe receipt, storage, administration and disposal of medicines.
• Staff understood the level of support people required with medicines and promoted independence with this where appropriate.

Preventing and controlling infection
• Practices were in place to ensure prevention and control of infection protected people.
• People and relatives told us staff wore gloves and aprons when they delivered personal care.
• People told us staff washed their hands before preparing food.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence 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.

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 that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. We checked whether the service was working within the principles of the MCA.

• The provider did not always respect people's right to make decisions about their health and wellbeing.
• One person had limited capacity and often refused care, but no capacity assessment had been made to assess whether they were able to make a decision in this area. A member of staff told us, "It can make you uncomfortable and awkward as I don't know what to do."
• People's records did not always consider the full range of diverse needs. For example, one person had limited mental capacity, but this had not been assessed to be able to support their independence as much as possible.
• When speaking with staff, it became clear that often decisions were being made by family members without considering what might be in the person's best interests.
• We saw assessments of capacity had not completed where required.
• Staff had received training for MCA but this knowledge had not been embedded within the service as capacity was not assessed and decisions were not being made in people's best interests.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
• Staff training and supervision was not always effective to meet the needs of people.
• Staff had received training in moving and handling techniques however, some staff did not feel this was adequate to put into practice. One person had equipment to assist them out of bed, but they had not been out of bed for many weeks due to staff not being confident in their training. A relative told us, "The staff are supposed to use the hoist, but none are trained so it is not used. It means [Name] must stay in bed and they

are getting so depressed. Their quality of life isn't great."
• A staff member told us, "The training in the classroom was good but it did not prepare me properly for using the hoist. I had to learn on the job and I felt quite vulnerable."
• One person told us, "The staff are not trained enough."
• The registered manager told us the provider was giving personal care but was unable to confirm what training they had to be able to do this role. The registered manager did not carry out supervisions with them.

• Agency staff used by the provider had not had an induction and were working with potentially untrained staff.

This was a breach of regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs and choices were not always planned and reviewed consistently to achieve best outcomes.
• For example, one person's condition had deteriorated but their care plan had not been reviewed and updated to reflect this. They were assessed as being able to use a piece of equipment with staff to get out of bed, but they were now receiving all care from their bed. A relative told us, "We have had no reviews even when there has been deterioration. There is no attempt to improve outcomes, they just leave them in bed."
• The care records seen for this person were no longer relevant to the care being given.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• The provider did not always work with other agencies to support people to have the best possible health outcomes.
• One person's condition had deteriorated, and staff had told the family to speak with doctors. The provider had not made any referral to other agencies or made any changes to the care given until this was approved by a healthcare professional. This meant the person was not receiving effective care that met their needs whilst the staff waited for extra input.
• Records showed that some referrals had been made to other health professionals, but low staffing levels impacted on the provider's ability to follow these up and keep this practice consistent.
• All the care plans were electronic and on secure work phones. This meant that when there was an emergency, or someone had to go to hospital, there was a delay in the care whilst paramedics spoke with the on-call worker to get a copy of notes.

Supporting people to eat and drink enough to maintain a balanced diet
• People were able to exercise choice and felt they received the support they needed with meals.
• One person told us, "I can choose my meals. They are done in the microwave, but the staff do it." Another person told us, "The staff do my meals for me and they leave me a drink between their visits."
• We read care plans which had prompts for staff to remind them to encourage people's fluid intake. The daily notes had a record of what people had eaten and drank during the visits.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence 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. Some regulations have not been met.

Respecting and promoting people's privacy, dignity and independence
• People's privacy was not always respected by the provider.
• Staff told us they used a communication application on their work telephones to discuss care of people using the service. We saw personal and identifiable information was being discussed on this application. This type of application does not offer a secure record of communication and so does not respect people's privacy.
• Prior to the inspection, we asked to see to the provider's assessment on privacy with this tool and found they were not meeting General Data Protection Regulation (GDPR) standards as people were not informed of how information about them was being processed.
• The provider did not always ensure people received care from familiar staff.
• People told us the high staff turnover and use of agency staff meant care staff were often unfamiliar.
• One person told us, "There is no regularity with staff. I never know who is coming or what time." Another person told us, "I have seen lots of different carers." A relative told us, "They are all lovely and polite but always new."

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care
• The provider did not always allow enough time for staff to support people.
• The provider did not allow for travel time between some calls and staff told us they felt under pressure to get to the next call. This meant that staff did not always have time to care for people.
• One member of staff told us, "I'm having to rush through the calls as sometimes travelling 30 minutes between calls but there was no allocated travel time." Another staff member told us, "I felt I was not able to stay for the time we had to. I had to cut down thirty-minute calls to fifteen minutes. People were getting annoyed and we were hassled."
• People and relatives told us the care staff were kind and caring.
• One person told us, "The staff are lovely. I can trust them and that is important." One relative told us, "Yes they are all nice staff. They go over the top to communicate with [Name] and that is lovely." Another relative told us, "Some of the staff have been so lovely with [Name]. They bought them flowers and have done their nails." Another person told us, "I'm independent and they respect that. They help where I need it with getting into bed and personal care." One relative said, "[Name] says they have carers that care."

Requires Improvement

Is the service responsive?

Our findings

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

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

End of life care and support
• People's end of life care needs were not always assessed and reviewed.
• Staff told us about one person who was coming to the end of their life. The provider had not taken steps to assess their end of life care needs or preferences.
• When reviewing care records, we did not see any evidence that end of life care planning was assessed for any of the people using the service. Staff recognised the difficulty with obtaining this information and identified this would be an area that they would keep under review.
• The provider did not always work with other healthcare professionals when people are at the end of their life to ensure good palliative care.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control;

• People did not always receive care that met their needs.
• People told us they were not always involved in planning their care. One person told us, "They did all the planning, but I wanted to be asked."
• Care plans were electronic and although the provider could allow access to records, some people told us they did not know how to do this. One relative said, "We have had no paperwork from them. It seems so disorganised."
• When reviewing care records, we saw care plans were not regularly reviewed. For example, we read one care plan which had not been updated since the person came out of hospital despite their care needs changing.

Improving care quality in response to complaints or concerns
• Complaints and concerns were not always investigated thoroughly to improve practice. Some people did not know how to make a complaint.
• One person told us, "I made a complaint to tell the staff my call was missed. They were nice to me, but I still didn't get a call that day." A relative told us, "I spoke with someone and asked about [Name's] care. They listened to me, but nothing ever materialised." Another relative told us, "I have never had to complain, but to be honest, I don't know how I would do."
• When we looked at records of complaints, there was no evidence of these concerns raised.
• The registered manager told us that not all complaints were recorded and analysed. This meant themes could not be identified to drive improvement.

Inadequate

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

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 being clear about their roles, and understanding quality performance, risks and regulatory requirements; Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility Continuous learning and improving care

- Quality monitoring systems were not effective to ensure people received safe care.
- Office staff were unable to demonstrate their ability to monitor missed and late calls to be able to identify patterns and protect people from potential neglect. The registered manager confirmed that an audit of missed and late calls was not done.
- A recent local authority inspection had identified the need to monitor missed calls, but this had not been actioned within the agreed timeframe.
- The audit process for medicines was not effective enough to identify gaps in the records. The audit monitored the computer system used and not the actual medicines record. We looked at one person's daily notes compared to their medicines record. According to the notes medicine had been given but the medicine record had a gap. The audit system used did not identify these discrepancies.
- The provider had not always understood the requirements of their registration with the CQC. Where safeguarding incidents had occurred, these had not been recognised nor reported to the safeguarding team or to us.
- The registered manager was unable to evidence to us that recording and analysis of accidents and incidents had taken place. This meant themes and patterns could not be identified consistently to ensure lessons were learnt.
- Systems were not in place to ensure people's care plans reflected the care given. For example, one person was now being cared for in bed, but their care plan detailed how they are to get out of bed.
- The provider did not support the management of staff and did not always allow the registered manager to have oversight of what all staff were doing.
- The provider was unable to evidence an adequate privacy risk assessment with regards to an electronic conversation system used between staff. This meant they were unable to maintain secure and complete records of care and treatment.

This was a breach of 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, fully considering their equality

characteristics
• The provider's engagement with people and staff was limited.
• The provider had not created an open and honest culture with staff. One member of staff told us, "We have no contact with the provider at all. We have been told never to contact them."
• Staff told us they did not always feel supported. One member of staff told us, "[Name] has been quite threatening with making me work long hours." Another member of staff told us, "They made everyone think there would be support but they have turned a blind eye to lots of us."
• One person told us, "From the top down the service is not good. I think it is terrible how the staff are treated by the firm."
• The provider did not always support and offer supervisions of the registered manager. This had impacted on their ability to develop systems to provide oversight of the service.
• The registered manager told us they telephoned people for their feedback on the service, but not everyone we spoke with had been given this opportunity.

Working in partnership with others
• The provider did not always collaborate with other services to develop care.
• The registered manager told us they were limited with improving their care plans in line with recommendations from the local authority, due to the provider wanting certain documents to be used.
• The provider had not reached out to other services available for support with gaps in knowledge or skills. For example, the registered manager told us they did not feel confident in carrying out mental capacity assessments, but they had not been supported to speak with the local authority to improve this knowledge.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider did not always ensure the privacy of the service user.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not always ensure that care and treatment of people was only provided with the consent of the relevant person. When people were unable to give such consent because they lack capacity to do so, the registered person did not act in accordance with the 2005 Act.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes had not been established and operated effectively to investigate and prevent abuse of service users.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to give care.

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 Care and treatment was not always provided in a safe way for service users and the registered person did not have systems to ensure risks were assessed and mitigated or to ensure adequate staffing levels.

The enforcement action we took:

We took action to impose a condition on the registration of the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not been established and operated effectively to assess, monitor and improve the quality and safety of the services provided.

The enforcement action we took:

We took action to impose a condition on the registration of the provider.