MJ CareCentre Limited

Bluebird Care (Brent)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Bluebird Care (Brent) is a domiciliary care service which provides personal care and support to people in their own homes. At the time of the inspection there were 127 people using the service, of which 91 were receiving 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
We have made one recommendation regarding accessible communication.

Moving and handling assessments lacked some detail and could be further developed. The assessments did not include the sling size, when the hoist was last serviced, hoist type, or what checks needed to be completed to ensure the sling was fit for purpose.

The provider did not have an effective system for reviewing lessons learned from incident investigation. For example, two recent falls incidents had not prompted action to prevent a recurrence of similar incidents.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People were protected from the risk of harm and abuse. There were effective systems and processes in place to minimise risks. Care workers had been recruited safely and they knew how to identify and report concerns.

People received person centred care. Their assessments showed they had been involved in the assessment process.

Care workers were knowledgeable about people's needs. They had completed essential training and we saw from records they were up to date with it.

People were protected from the risks associated with poor infection control because the service had processes in place to reduce the risk of infection and cross contamination.

There were governance structures and systems which were regularly reviewed. There was a complaints procedure in place, which people's and their relatives were aware of.

Quality assurance processes such as audits and spot checks were in place.

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

Rating at last inspection
The last rating for this service was good (published 13 May 2019).

Why we inspected
The inspection was prompted in part by notifications of two incidents following which two people using the service sustained serious injuries. The incidents are subject to initial inquiries to determine whether to commence a criminal investigation. As a result, this inspection did not examine the circumstances of the incidents. However, the information shared with CQC about the incidents indicated potential concerns about the management of risk of falls from moving and handling equipment. This inspection examined those risks.

You can see what action we have asked the provider to take at the end of this full report.

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 breaches in relation to risk assessments and a lack of an effective quality assurance system.

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 effective?

Requires Improvement

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

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

Bluebird Care (Brent)

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
The inspection team consisted of two inspectors and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

The service did not have a manager registered with the CQC. There were arrangements for the manager to be registered with CQC.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because we needed to be sure that the provider or the manager would be in the office to support the inspection. We visited the office location on 26 August 2022.

What we did before the inspection
Prior to the inspection we reviewed information and evidence we already held about this service, which had

been collected via our ongoing monitoring of care services. This included notifications sent to us by the service. Notifications are changes, events or incidents that the provider is legally obliged to send to us without delay. This information helps support our inspections.

During the inspection
We spoke with 17 relatives of people who used the service to help us understand the experience of people who could not speak with us. We also spoke with nine people using the service. Some people we spoke with had limited mobility and required support with transfers. We spoke with the manager, two service directors, care coordinator and seven care workers. We reviewed the care records of seven people using the service, personnel files of seven care workers and other records about the management of the service.

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 Good. At this inspection the rating has changed to 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.

Assessing risk, safety monitoring and management
• Risk assessments were not detailed. For example, risk assessments and the related moving and handling care plans did not contain the sling size, when the hoist was last serviced, hoist type, or what checks needed to be completed to ensure the sling was fit for purpose. One risk assessment read, "The care workers then need to attach the sling to the hoist using the correct straps on the correct loops" but did not go on to specify which specific coloured loups were used to hoist the person safely. Another file instructed care workers to use a particular equipment, but the risk assessment and manual handling procedures did not include relevant information, such as the type and size of the slide sheet, putting both breaks on, use of side and central bars. Further details were required to facilitate safe transfers.
• Falls risk assessments were updated in care plans we reviewed. However, there was no record of escalation to the commissioners and or the GP for further support or more information about falls prevention strategies implemented following both witnessed and unwitnessed falls. Furthermore, although staff were able to explain the procedure they would take if they found someone on the floor, none of them mentioned completing incident or accident forms until prompted.

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

• We spoke with people who had limited mobility and requiring support with transfers such as getting into a bath and from the bed to the chair. Notwithstanding our findings when reviewing risks assessments, they all told us staff were competent. Their feedback included, "[My relative] transfers from bed to chair using a particular transfer aid. The staff are competent and well trained and do not take any risks. We've had no problems", "Staff are properly trained for hoisting. They take their time" and "We have a ceiling hoist with tracking and the [care worker] is trained to use it."

Learning lessons when things go wrong
• There was an incident/accident reporting system but this was not fully utilised. The process for disseminating information on lessons learnt to all relevant parties (both internal and external) was not effective. For example, staff could not remember having any discussions in relation to lessons learnt following recent incidents of falls. We did not see any evidence to support how any lessons learnt were effectively cascaded to staff.
• There were no adequate systems in place to ensure sufficient action was taken to identify and respond to incidents. For example, we found inadequate consideration of root causes or organisational factors in the analysis of recent falls incidents. This was important to ensure that the underlying as well as immediate

causes of accidents and incidents were understood. Therefore, by not considering all factors, it meant opportunities for learning lessons were limited.

This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
• There were systems in place to ensure proper and safe use of medicines. There were policies and procedures in place. Medicine administration records (MAR) were completed appropriately and regularly audited.
• Staff had received medicines training. Medicine administration records we reviewed were completed properly. Any gaps were identified during monthly audits. We saw that care workers had received support and supervisions when they had forgotten to sign for medicines or to record medicines refusals.

Systems and processes to safeguard people from the risk of abuse
• People were protected from the risk of harm and abuse. There were policies covering safeguarding adults, which were accessible to all staff. They outlined clearly who to go to for further guidance.
• Staff understood their responsibility in identifying, responding to, and escalating suspected abuse. They told us they would report any allegations of abuse to the office. They were aware they could notify the local authority, the CQC and the police when needed.
• Records showed staff had received up-to-date safeguarding training appropriate to their role.

Staffing and recruitment
• There were sufficient care workers deployed to keep people safe. People were receiving care and support from staff that had undergone the necessary safer recruitment checks.
• We reviewed staff recruitment files and found applications on file. Employment history had no gaps and references were verified and were on file before staff started employment. Disclosure and barring checks were completed before staff started to work. These checks helped to ensure only suitable applicants were offered work with the service.
• Staff told us that although it had been challenging during the COVID-19 pandemic, there were usually enough staff to ensure that people received consistent care at a time of their choice.
• A relative told us, "Sometimes I stay overnight and so I am there when the [care workers] come and they have always been on time or thereabout". Another relative said, "The [care worker] always comes on time and stays the full amount of time."

Preventing and controlling infection
• The provider had arrangements in place for preventing and controlling infection. This included making sure there was enough personal protective equipment (PPE) and ensuring staff had the necessary infection control and food hygiene training.
• Staff confirmed they had access to PPE, such as masks, aprons and gloves. Staff told us they could access additional PPE from the office as and when needed and kept extra stock in their cars.

Requires Improvement

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.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed before they started to use the service. People's care needs were identified, and the manager ensured the team could meet those needs. Information gathered from the assessments was used to create care plans and risk assessments. The care assessments were reviewed yearly or when people's needs changed.
• Relevant guidelines were in place, including those drawing from the National Institute of Health and Clinical Excellence (NICE).

Staff support: induction, training, skills and experience
• Staff did not always receive comprehensive competency assessments to make sure they had the correct skills to support people with medicines. We found that medicines competencies and moving and handling competencies were in place but not robust enough. Two out of six records we reviewed showed that these competencies were not completed properly to ensure staff had been assessed on various aspects of moving and handling and medicines administration. For example, one competency for moving and handling was not signed off fully to confirm that the staff member was competent in performing individual tasks such as assisting with hoist. Similarly, two medicines competencies were not completed properly. All competencies must be completed accurately in order to fully assess staff's understanding of the topic. Following the inspection, the provider submitted evidence, which showed that they had developed a new process to improve competence monitoring.
• Care workers had appropriate training and experience to meet people's needs. Training was completed in house at the office and refreshed annually. However, we noted that the training was packed over four days. Staff we spoke with said the training was good but intense. The provider confirmed during a discussion with us that they were reviewing the training program as it was too much for staff to comprehend in one go.
• Staff received an induction aligned to the Care Certificate. The Care Certificate is the recognised standard for training for staff new to health and social care. Care workers described how they were able to shadow more experienced staff until they were confident enough to deliver care on their own.
• Induction records were in place and included two days of shadowing. One staff member told us they had an extension on their induction until they were ready to work on their own.
• Staff told us and records we reviewed confirmed that appraisals were in place. Personal development plans included any further training or qualification that staff wanted to achieve.

Supporting people to eat and drink enough to maintain a balanced diet
• There were arrangements to ensure people's nutritional needs were met. People's needs were assessed in

relation to eating and drinking safely where this was appropriate. Care workers understood the support people needed and described how they provided this consistently.
• People told us care workers were available to make sure they had enough to eat and drink. They also said fresh water or squash was readily available and within reach, which ensured they had access to drinks regularly.

Supporting people to live healthier lives, access healthcare services and support
• People's health needs were met. Their care plans identified their needs and input from a range of professionals, including GP, district nurses and occupational specialists.
• People's relatives told us care workers accompanied people or arranged visits to hospitals and appointments with GPs.

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 when this is in their best interests and legally authorised under the MCA.
When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

• The service was working within the principles of the MCA. People told us care workers obtained consent before they could proceed with any task at hand. Consent forms were in place in care plans we reviewed.
• Relatives told us people were aware of their care plans and had been involved in their development. They told us their consent was always sought.
• People or their representative signed care plans. These showed consent to care and treatment had been obtained. Where people had been unable to consent to their care, best interest decisions had been made to provide support. Lasting power of attorney (LPA) documents were recorded clearly. An LPA is a legal document in which someone gives another person the right to help them make decisions or take decisions on their behalf.

Good

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.

At our last inspection we rated this key question Good. The rating for this key question has remained Good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Respecting and promoting people's privacy, dignity and independence
• People's relatives told us care workers were kind and caring. Their feedback included, "[The care worker] is wonderful. She is so caring", "The staff are lovely and very obliging" and "Staff are very nice. They treat us with respect."
• People's privacy was respected. The care plans described how people should be supported so their privacy and dignity were upheld. People could describe how the agency protected their privacy and dignity. One person told us, "[My care workers] support me with a shower and they are very respectful." Another person said, "They always ring the bell and I let them in."
• Privacy and confidentiality were also maintained in the way information was handled. Care records were stored securely in locked cabinets in the office and, electronically. The service had updated its confidentiality policies to comply with General Data Protection Regulation (GDPR) law.
• People were supported to maintain their independence. They told us how care workers took time to support them to participate as fully as they could. One person told us, "My [care worker] supports me to do things myself. The [care worker] does exercises with me for my feet and legs to help me be more mobile." A relative told us, "Our [care worker] helps with mobility and exercises and encourages [my relative] with walking. [The care worker] is like a fairy godmother."
• Staff told us how they treated people with dignity and respect and encouraged independence. They said they would ask how people wanted to be supported at the beginning of the visit and encouraged people to do what they could such as wash their face. They said they would leave snacks and items like remotes and phones within people's reach so they could have access in the absence of staff.
• Staff we spoke with knew people they supported well and told us how they addressed people by their preferred names and respected their choices. Care plans detailed people's personal wishes, and preferences. This meant staff could respect people's individuality.

Ensuring people are well treated and supported; respecting equality and diversity
• The provider respected people's diversity. Care workers had received equality and diversity training. They understood the importance of treating people fairly, regardless of differences. Relevant policies were in place, including, equality and diversity and Equalities Act 2010. This helped ensure people's individual needs were understood and reflected in the delivery of their care.
• Practical provisions were made to support people's diversity. People were matched with care workers on grounds of mutual language, religion and culture. For example, people were matched with care workers who could speak the same language. A relative told us, "Our [care worker] speaks Gujarati, and that is what we wanted."

Supporting people to express their views and be involved in making decisions about their care
• There were systems and processes to support people to make decisions. As addressed earlier, care workers were aware of the need to seek people's consent before proceeding with care.
• People told us and their records showed they had been fully consulted about their care. The provider maintained regular contact with people through telephone calls and reviews. This gave people opportunities to provide feedback about their care, which was acted on. A relative told us, "We are always involved in any decisions about care."

Requires Improvement

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. At this inspection the rating has changed to Requires Improvement. This meant people's needs were not always met.

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.

• Care plans did not consistently address people's communication needs. For example, one person was registered blind but the care plan instructed staff to show their ID badge to the person on arrival. The care plan was also not available in a format that was understood by the person. There were no details that showed the person had been asked how they preferred to receive information.

We recommend the provider consider current guidance on implementing the Accessible Information standards so as to meet the communication needs of all people using the service.

• All other care plans outlined people's communication needs and preferred method of communication. This enabled staff to communicate in people's preferred way. For example, people were matched with care workers on grounds of a mutual language, including Gujarati and Hindi.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• Most people told us they received person centred care. Their care files contained meaningful information that identified their abilities and the support required. This included people with limited mobility, who required support to be transferred.
• Staff told us they had access to care plans on mobile devices. Care plans referred to peoples likes and dislikes.
• People received support that met their individual needs. A relative told us, "[My relative] is hoisted and sometimes the two [care workers] come separately. One will come early but does not hoist until the other one arrives. I have watched the [care workers] and it is always been done properly." This was consistent with feedback we received from most people, including those who required support with mobility.
• Care workers were aware that they needed to stay with people until an ambulance came in the event of an emergency. They told us they would call the office who would in turn get cover for their next visit. A relative told us, "My relative had a fall and [sustained injuries]. I phoned the [manager] and a [care worker] was sent straight away. The [manager] came too. They phoned the paramedics and [my relative] was taken to hospital. They were very good."
• Care workers were knowledgeable about people's needs and could describe to us how people liked to be

supported. This was also enhanced by the fact people had a regular team of care workers, which ensured they were familiar with people's individual needs.
• Care plans were regularly reviewed to monitor whether they were up to date so that any necessary changes could be identified and acted on at an early stage. A relative told us, "We have had a care plan and we have regular reviews with the agency to make sure everything is as we want it."

Improving care quality in response to complaints or concerns
• The service had a complaints procedure. The procedure gave details of the process for reporting complaints. The policy had been shared with relatives. There were no pending complaints. A relative told us, "I haven't had to make any complaints but if I did, I have complete trust in the manager."

End of life care and support
• The service did not provide end of life care. However, people's care plans contained information about their religious beliefs, and some contained basic information about their wishes should their care needs increase.
• The manager explained that they would ensure all care workers received relevant training and support that they needed to provide people with end of life care if the need arose.

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 Requires Improvement. The rating for this key question has remained Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements, Continuous learning and improving care

• Although the provider had systems in place to monitor the quality of the service and to make improvements when needed, these were not always effective. There were areas of the service where improvements were needed or could be developed, to ensure people were safe and received effective personalised care. These areas included, the need to make sure manual handling assessments were detailed, escalation of falls incidents to GPs and commissioners and to the need ensure competency assessments were fully completed

• The provider did not assure us that action was consistently taken to minimise the risk of similar incidents reoccurring. For example, we reviewed an incident log of January 2022 and noted there was one missed visit and 48 late visits. The provider's analysis concluded that 11% of the incidents were due to care workers not checking rotas properly or overstaying in the previous visits, 46% were due to public transport and traffic delays, with the other 2% due to office administration errors. In their findings the provider concluded that staff should always contact the office, should they experience delays. This was the same conclusion for subsequent months. However, we were not assured that the analysis and action taken were sufficient for the required improvements.

• This was also true of the conclusions reached for the unwitnessed falls. One fall was recorded in March 2022 and another in April 2022. In both the provider concluded that they should continuously carry out spot checks and holding customer reviews to make required improvements. However, we were not assured the analysis and conclusions were comprehensive to ensure suitable interventions were put in place to prevent a recurrence of the incident or similar incidents.

This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider was receptive to our feedback and took things on board. Following the inspection, we received evidence which showed improvements had started to be made to relevant areas. However, it was too early for the provider to be able to demonstrate that these processes were fully embedded and that these improvements could be sustained over time.

• Audits had been carried out through the "spot check" process. A relative told us, "The manager is very good, and there is always someone on the phone to speak to. I can ring up at any time. They ring me to check all is well too, and make sure I am happy. Once a week there is a visit to [my relative] and the manager

speaks to the live-in staff to ensure all is well."
• The service had a range of policies and procedures to ensure that care workers were provided with appropriate guidance to meet the needs of people. These addressed topics such as, medicines management, safeguarding and equality and diversity.
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 provider told us they had complied with the duty of candour by being transparent with family members of people they supported. Duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• There were a range of formal systems, which ensured people had choice and control over their care. People participated in regular reviews, surveys and meetings.
• People received regular unannounced spot checks and telephone calls. This ensured they were consulted and given opportunities to comment about their care.
• The manager was knowledgeable about the characteristics that were protected by the Equality Act 2010, which we saw had been fully considered in relevant examples. As addressed earlier, people's religious or cultural needs were met.

Working in partnership with others
• The service worked in partnership with a range of health and social care agencies to provide care to people. These included, GPs, district nurses, pharmacists and occupational therapists.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not consistently complete comprehensive risk assessments relating to the health, safety and welfare of people using services, and adopt control measures to make sure the risk is as low as is reasonably possible.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems and processes to identify where quality was compromised and to respond appropriately and without delay.