Robelen Enterprises Ltd

Bluebird Care Newham

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 6, 7, 8 and 12 January 2015 and was announced. The provider was given 48 hours' notice as they are a domiciliary care agency and we needed to be sure someone would be in. The service provides support to approximately 60 people living in their own homes.

The service had a Registered Manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service was last inspected in March 2014 when it was found to be compliant with the outcomes inspected.

People gave us mixed feedback about the service. People told us their regular carers were good and caring, but found that the service was not good when their regular carers were not available.

Care files were of a poor quality, they were task focussed and contained limited personalised information.

Risk assessments were insufficient. They were not robust and did not provide staff with the information they needed to reduce the risk of harm to people.

Where the service supported people with their medicines this was done by trained staff. However, associated medicines plans and records were poorly completed and people were at risk of not having their medicines administered as prescribed.

Where the service supported people with eating and drinking the information contained in their plans was insufficient and did not include information on specialist diets or how people liked to be supported.

Staff recruitment procedures were not robust and people were at risk of being supported by staff who were not suitable to work in a care environment. The service had not taken appropriate steps to ensure that staff were suitable to work with people in their homes.

Systems to monitor the quality of the service were not effective. The service did not consistently learn from complaints or incidents or use these to drive improvements to the service. The management and leadership of the service were not effective. We have made a recommendation about learning from incidents, accidents and complaints.

People felt safe and the service had safeguarding policies and procedures which were understood by staff. People had given their consent to their care and were involved in reviewing their care packages regularly.

People felt they were treated with dignity and respect. The service attempted to provide care workers who spoke the same language as people who used the service.

Staff received sufficient training and support to ensure they were suitably qualified to carry out their roles.

We found four breaches of regulations. You can see what action we have taken at the end of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, 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 take action 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.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people were not managed well and people were not protected from the risk of avoidable harm.

There were not enough staff to cover absences. Safe recruitment practices had not been followed. This put people at risk of harm.

People's medicines were not managed effectively and people were therefore at risk of not having their medicines administered correctly.

People told us they felt safe with their staff. Staff had received training in safeguarding adults and knew how to report on concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

Care files did not contain sufficient information to ensure people were supported to eat and drink enough and maintain a balanced diet.

Staff had received the training they needed to carry out their roles and responsibilities.

People provided consent to their care in line with legislative requirements.

People were supported to access health professionals.

Is the service caring?

Good

The service was caring.

People told us the staff were caring.

People were involved in making decisions about their care and treatment.

People told us they were treated with dignity and respect. People's cultural and religious backgrounds were respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were task focussed and lacked personalised information.

People were involved in reviewing their care and where necessary care plans were updated.

People knew how to make complaints and complaints were resolved in line with the policy.

The service did not always learn lessons from incidents.

Is the service well-led?

Inadequate

The service was not well led.

The service could not demonstrate good management and leadership. Delegation of management tasks had been ineffective.

Quality assurance and audit processes were ineffective and did not identify poor practice.

Bluebird Care Newham

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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.

This inspection took place on 6, 7, 8 and 12 January and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

The inspection team consisted of a three inspectors and an expert-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. This expert had experience of caring for someone using a domiciliary care service.

Before the inspection feedback was requested from the local authority commissioning team, the local Healthwatch and the local advocacy service. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we already held about the service, including statutory notifications we had received.

During the inspection we spoke with six people who used the service and four relatives. We spoke with ten members of staff including the Registered Manager, the Care Manager, a coordinator and six care workers. We viewed 7 staff files including recruitment records, supervisions and appraisals. We viewed the care files of nine people who used the service including support plans, risk assessments, medicines records, needs assessments and records of care delivered. Various records and policies including the safeguarding policy, incidents, complaints, quality assurance, recruitment policy, training records, staff meeting minutes and feedback forms were viewed.

Inadequate

Is the service safe?

Our findings

People said they felt safe with staff. One person said, "I always feel safe with them." Another person said, "I feel very safe with the carers, they make me feel at ease." Relatives also told us they felt their relatives were safe using the service. One relative said, "I feel [relative] is safe with the carers." Staff explained safeguarding procedures and demonstrated they knew the different types of abuse and what they should do if they suspected abuse. The service had produced cards that had been distributed to staff which included details of different types of abuse and what they should do if they suspected abuse. The service had robust policies regarding safeguarding and whistleblowing. However, these did not contain the local information required, such as the local authority contact details. Within the policy documents where the local contact details should have been contained it was stated "insert contact details".

Care files contained sections for various risk assessments to address risks including those posed by the environment, the completion of care tasks, moving and handling, nutrition and hydration and the administration of medicines. These were poorly completed and did not contain sufficient information to manage risk. For example, one person had high physical support needs, was unable to mobilise independently and required the support of a hoist for all transfers. In the section of their risk assessments that were meant to describe how to support them there were no descriptions of how to do so. Statements included, "Unable to sit up and stand without physical assistance." And "It is important I wear my back brace" However, there were no details of what the physical assistance should be and how it should be provided safely.

Another person's risk assessment stated that support with showering and bathing had not been risk assessed and no staff from the service were to support with this task. However, the person's care plan described support with showering. This meant that staff were completing a task that had not been risk assessed putting both them and the person at risk of harm. In a further example, one person was identified as being at high risk of developing pressure wounds. The risk assessment stated, "Check pressure areas carefully and report any concerns to district nurses." There were no details of what would constitute a concern and no guidance for staff on how to contact the district nurses. In other files records of care showed the use of moving and handling equipment that was not listed in risk assessments or support plans. This meant people were at risk of receiving unsafe support.

The service supported people with complex medical conditions, including people at the end of their lives, people with multiple life limiting conditions and epilepsy. Where these health conditions meant that people were at risk of harm, for example, through seizures, there were not always guidelines in place for staff to follow to keep people safe. For example one person had epilepsy but their file contained no information for staff on how to support the person in the event that they had a seizure.

The service provided support to people with their medicines, including people who had complex health conditions with multiple medicines prescribed. Staff told us, and records confirmed they received training in administering medicines. Records showed the systems the service had in place did not ensure that people were supported to receive their medicines safely. People who were supported to take medicines had a

specific medicines support plan and risk assessment as well as medicines administration records (MAR). The medicines listed in the support plans did not match the medicines listed on the MAR in three of the seven files viewed. Instructions for the administration of medicines were not clear. For example, one person's support plan stated that each medicine should be "administered before after food" This included a medicine that should be administered before food. This was an unclear instruction for staff to follow. Another person's medicines support plan and MAR chart included a dosage of medicine that was not made. This meant staff could not have been administering this dose as described as it does not exist. This person also had been prescribed different strengths of the same medicine which was described as to be administered both orally and topically, it was not clear if this was a cream or a tablet. This meant that staff could not have administered the medicines as described. None of the files viewed contained information on the purpose or potential side effects of medicines. Where people were prescribed medicines on an "as needed" (PRN) basis there were no guidelines for staff on the circumstances when these medicines might be needed or should be offered.

The records of medicines administered contained errors. One person's records showed 19 occasions in one month when a lunchtime dose of medicine was not administered without an explanation recorded. This person was also prescribed pain relieving medicine twice a day but records showed they only received one dose a day for three weeks. This meant the person was at risk of being in pain. There were missing or additional signatures in three of the seven records checked. Records of care delivered showed that one person was receiving pain relief medicine that must be spaced at least four hours apart without the required time gap. This put the person at risk of overdose. Another person was prescribed a medicine to relieve tremor, this medicine must be administered at specific times as it was 'short acting'. This means it wears off and symptoms return. Records showed no signature for their lunchtime dose two days running.

The above issues with risk assessments and medicines are a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People and relatives told us they had regular care staff who worked with them. Records of care delivered showed that where two staff were required they attended and there were no records of missed visits. However, people also told us that there were sometimes problems if their regular care worker was on holiday or unwell. One relative told us they were making a complaint as recently only one member of staff had been coming when two were required. Most people told us they did not think the service had enough staff and that when their regular carer was unavailable care staff were late in arriving. One person said, "I have had three different carers this week. The carer they said would be coming didn't come, she had been sent somewhere else." Another person said that when they were informed that their usual staff could not attend they cancelled their support rather than have a different member of staff. When we asked people if they thought the service had enough staff one person said, "They have a problem when a carer cannot come. I always get a phone call and I generally say leave it for today." Another person said, "No. sometimes the carers come early sometimes they come late. When they come late there is never a phone call to say they are delayed." This meant the service did not have enough staff as they could not cover absences without running late and people cancelling their support.

Staff files viewed showed the service did not follow safe recruitment processes and could not demonstrate that staff employed were suitable to work in care. Records showed that three staff had been employed and were working in people's homes who had information on the Disclosure and Barring Service (DBS) check. This means that there was some kind of arrest, caution or conviction in their past. The service had performed no follow up on this information to establish if this was information that would mean they were unsuitable to work in care. All three staff had signed a declaration stating they had no convictions. The Registered Manager was unaware staff were working with information recorded on their DBS checks until

inspectors brought it to his attention. Records showed that gaps in staff member's employment history were not routinely explored during interviews and dates of employment provided by applicants did not match dates supplied by references. The relationship between referees and applicants was not clearly recorded which meant it was not clear if the reference was a personal character reference or an employment reference. This meant that the service was not checking that people had provided a complete and accurate employment history and was not performing sufficient checks that staff were suitable to work in care.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Requires Improvement

Is the service effective?

Our findings

Staff told us, and records confirmed that they received an induction before they started working with people. This included training on health and safety, medicines awareness, manual handling, first aid, the Mental Capacity Act 2005, fire safety, safeguarding adults and children, infection control, end of life care, and customer care. The Registered Manager told us they were working towards all staff completing the Care Certificate. The Care Certificate is a qualification which gives staff a foundation in the knowledge and skills required to work in the care field. The provider did not hold a central record of training, certificates were held either in a central file or in individual staff files. The provider used a staff scheduling system which allowed them to record staff training and skills within it. However, it was not completed at the time of our inspection. The Registered Manager told us they aimed to get this system completed in the near future.

Staff told us, and records confirmed that they shadowed more experienced staff when they started working. The length of time that they shadowed for varied and this depended on their previous experience and confidence in the work. Supervision records confirmed that moving on to working independently was discussed and agreed between staff and their supervisors. Staff told us they had regular supervisions which they found useful. Records confirmed that staff had weekly supervisions during their probation and monthly supervisions thereafter. People and their relatives told us they thought staff were good at their jobs, though one person did say that new staff sometimes needed training. In one person's review notes we saw a relative had requested that only staff with specific training supported their relative.

People told us staff asked their permission before supporting them. One person said, "They always ask, they'll say 'shall I help you with [care task]" Each person's file contained a section relating to consent which included questions about whether or not the person had anyone legally appointed to make decisions on their behalf. People or their relatives where appropriate had consented to their care plans.

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. Where people lacked capacity to consent to their care and treatment records showed appropriate relatives had been consulted and agreed that the care plan was in their relative's best interests. However, formal capacity assessments or records of best interests meetings were not in people's files. The service relied on assessments conducted by the local authority regarding people's capacity to consent to their care and treatment.

We recommend the service seeks and follows best practice guidance on recording mental capacity assessments and best interests decision making.

People told us, and records confirmed that most people were supported by family members with their meals. However, there were some care files that showed the service was responsible for preparing meals and supporting people to maintain a nutritious and balanced diet. Plans were not sufficient to ensure that

people received a healthy diet. For example, one person was receiving ongoing treatment that severely restricted their diet and meant they would be at risk of harm if they consumed too much salt. The service supported this person with meals but there were no risk assessments or guidelines about food preparation. Another person required full support with both meal preparation and eating, while there was information about their preferences, the description of how to support them was unclear and put them at risk of poor support. Staff were instructed to "hold my head" but were given no details of the way in which to do this safely.

The service provided support for people with a range of complex health conditions, however, most people were supported to liaise with health professionals by their relatives. People told us they did not receive support to access health services from the service. Where the service had a role in escalating concerns to other health professionals this was recorded in people's care plans, for example, one person's plan stated that staff should raise concerns about a person's skin with the district nurses. Staff told us they would report any concerns they had about someone's health to the office who would liaise with the relevant health professionals. A relative told us they regularly received calls from the service regarding their relative's health.

Good

Is the service caring?

Our findings

People told us they thought the staff were caring. One person said, "They have a very caring attitude. They are all very kind." Another person said, "They are always very helpful and eager to please." Relatives also told us they thought staff had a caring attitude, one relative said, "The staff are very caring."

Staff spoke about the people they supported with kindness. They said they were given background information by the office staff and then used the care plans to build up a picture of the person. Staff and people told us they worked with regular people, and this meant they were able to build up relationships. One staff member said, "I work with regular people, we talk in time and they tell you about their life, we build it together."

Care files recorded if people practiced a religious faith and if they had specific language requirements. One member of staff explained how they supported someone to maintain their faith, they said, "We give [person] their holy book before we go." Records of care delivered showed that where people did not speak English staff who spoke the person's mother tongue were provided, though review notes showed and feedback from people and relatives included that this was not always provided. One relative said, "We asked for a person who could speak our language. The office are quite accommodating when we ask. [My relative] will work around someone who cannot speak her language and somehow manages okay."

Staff described how they promoted people's dignity when working with them. One member of staff explained how they promoted choice and dignity when supporting people by saying, "We say good morning. Say 'today we are going to have a wash.' Before we test the water and ask if it's ok. We close the door so no one comes in." People and their relatives told us they felt that staff respected their dignity and promoted their independence. One person told us, "I am always treated with dignity by the carer, probably only one of the few people I meet who choose to treat me with dignity."

Review records showed that people and their relatives were given the opportunity to provide feedback on their care and make decisions about their plans. People told us they had been able to choose the gender of their staff. The service had held a Christmas party to which all people using the service had been invited. In the Provider Information Return the Registered Manager had told us they planned to involve people and their relatives in recruitment, according to the PIR this should have been in place by the time our inspection took place. However, the Registered Manager told us this had not happened and none of the people or relatives we spoke to had been invited to be involved in recruitment. Both people and their relatives told us they had not been invited to complete surveys or to come to meetings, but they did tell us they had meetings with staff from the office at least once a year where they talked about their care.

Requires Improvement

Is the service responsive?

Our findings

Care files were task focussed and were not personalised to people's needs. In one person's file it stated, "I need 24 hour care including a waking night and I would require a combination of 1 and 2 carers throughout the day to meet my care needs and transfers. I also need regular turning and repositioning throughout the day and night." This did not match with any other information within this person's care plan and seemed to relate to a different person. Likewise, in a different person's medication support plan and MAR chart we found a page from another person's MAR record. Descriptions of support to be provided were generic and lacked detail regarding individual preferences. For example, people's plans repeatedly stated "Assist me" and "Support me" with various care tasks but provided no detail on what assistance or support meant.

Two of the files viewed contained information that stated that the person could exhibit behaviours which challenged the service. The tone of these statements was not personalised or appropriate. In one file the person was described as "Behaviour is clearly challenging, as [person] is either unable or unwilling to comply with advice." There was no accompanying guidance for staff describing the nature of the behaviour or advising on how to manage them. In another file information provided by social services indicated this person posed a high risk to themselves due to impulsive behaviours. The only guidance for staff was that they should "Please hold my hand and speak to me to enable me to calm down. Also move me to a quiet area." This person was described as becoming "unsettled" and "agitated" but there were no descriptions of behaviours that may indicate that staff should intervene or guidance on how to intervene positively.

Support plans contained information on people's ability to communicate. Where people could use speech to communicate this was clearly recorded. However, where people had difficulties using speech there was no information regarding alternative forms of communication. For example, one person was described as having "limited speech" and their plan stated, "I know a few words so people have to be patient with me." There was no information on which words this person did know. In addition, the plan stated the person expressed themselves using body language, but there were no descriptions of how they used body language to express themselves. This meant there was no information for staff to use to work out if the person was expressing pain or displeasure.

People and relatives told us and records confirmed the service reviewed people's care and support at regular intervals. Most people had annual reviews, but when requested by people this was done more frequently. Feedback provided through these reviews was positive. However, when people had requested changes to their packages of care these had not happened. For example, one person had requested during their review in August 2015 that they move some of their support to the weekends. At the time of our inspection in January 2016 this had not happened. The Registered Manager informed us this was because they were awaiting additional funding from the local authority for additional hours, but the review notes record changing hours rather than additional hours. This change would not require authorisation from the local authority.

The above is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff told us that they would tell office staff if they had concerns that someone's needs had changed and they required additional support. The Registered Manager described how concerns were escalated with the local authority when care packages needed to be adjusted. One member of staff described how a person they supported now received longer calls as a result of escalating these concerns.

The service had a complaints policy which detailed the timescales for response and how to escalate concerns. It was included in the service user guide which was given to all people receiving a service. People told us they knew how to make complaints and raise concerns. One person said, "If I'm not happy I phone or email the boss. It always gets sorted out." Another person told us they were in the process of making a formal complaint. Records of complaints made in the last year showed the service had followed the policy and resolved people's complaints.

The service had a policy regarding incidents and accidents. This detailed that incidents and accidents must be recorded and reported in a specific way. Records showed four incidents had been recorded in the last year. Records showed what action had been taken in response to these incidents, however, there was no record of analysis of the cause of incidents or lessons learnt. This meant the service was not routinely learning from people's experiences. In one person's file we found correspondence relating to an incident where poor moving and handling practice had caused bruising. Although the Registered Manager was able to provide us with correspondence which demonstrated the actions that had been taken, this had not been recorded as an incident in line with the policy.

We recommend the service seeks and follows best practice guidance on responding to and learning from incidents, accidents and complaints.

Inadequate

Is the service well-led?

Our findings

People and staff told us that the Registered Manager was responsive and supportive. One member of staff told us they had met with the Registered Manager to discuss the number of hours they were being asked to work and he had responded positively. One person said, "The manager is approachable. He always takes emails or phones. We keep on good terms."

The Registered Manager had delegated a number of key audits to other staff in the organisation. These included quality checks and file audits. Records showed that audits of medication records had not been completed since October. This meant that the errors discovered on inspection had not been picked up or addressed in a timely manner. In addition, where audits had taken place and errors found, the action taken was always that "staff spoken to." This had not been an effective measure as errors had continued.

The provider had a policy which stated that records of care delivered should be audited monthly. Records showed that this was not being completed regularly in line with the policy. Our audit of care records showed that one person was not receiving care visits in line with their care plan. The person's plan stated they were meant to receive four visits per day. Records showed that between 8 December 2015 and 3 January 2016 they received four visits on four occasions, three visits on ten occasions, two visits on eight occasions and one visit on two occasions. The audits were not taking place and therefore had not identified these issues.

When this was discussed with the Registered Manager he said, "It had been delegated and had become unclear. I was surprised by some of those things [issues the inspector had brought to his attention]." The ineffective delegation of quality checks meant the service had not identified when it was delivering poor quality care. The delegation of audits to other staff had been completed without providing those staff with any training on the process they were to complete. The Registered Manager told us they relied on the training these staff had received from previous employers. This was not effective management as the specific requirements had not been clearly established.

The Registered Manager conducted audits of care files and staff records. Records of these audits were viewed from June, September, October and December 2015. The audits involved checking 15 aspects of care files and 30 aspects of staff files. Each audit was contained in a separate document. This meant that it was very difficult to track progress between audits as each individual had to be looked up individually. Action plans were not produced following the completion of audits so it was not clear if the service was learning and developing through a quality assurance process. These audits had not identified the issues we found on inspection, and concluded that care files were complete and accurate when we found they were not. Likewise these audits had not identified the issues with recruitment processes, reference checking and criminal records checks that our inspection identified. This meant they were not effective.

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

The Registered Manager told us, and staff confirmed that regular staff meetings were held. Records were viewed of the weekly office staff meetings which showed they were used to plan the workload and ensure

that out of hours cover was provided. The records of staff meetings for care workers were incomplete, though care workers informed us they were used to ensure they were up to date with key information about the service. Staff told us and records confirmed they had annual appraisals from the registered manager.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans contained insufficient information to meet people's needs and reflect their preferences. Regulation 9 (1)(b)(c)

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 Risk assessments and control measures were insufficient to mitigate the risk of harm to service users. Medicines were not managed effectively which put people at risk of harm.

The enforcement action we took:

We have impossed a condition on the provider's registration

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not operating effectively to ensure the quality of the service.

The enforcement action we took:

We have imposed a condition on the provider

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Appropriate checks on staff had not been carried out. Where checks had been performed the service had not taken action to ensure staff employed were safe and suitable to work in a care setting.

The enforcement action we took:

We have imposed a condition on the provider.