VEF Wilson Ltd

# Bluebird Care (Southend & Rochford)

**Inspection report**

799 London Road,
Westcliff on Sea,
Essex
SS0 9SY
Tel: 01702 474274
Website: www.bluebirdcare.co.uk/southend

Date of inspection visit: 14 January 2015, 16 January 2015, 19 January 2015 and 20 January 2015
Date of publication: 03/07/2015

## Ratings

| | |
|---|---|
| **Overall rating for this service** | **Requires improvement** |
| Is the service safe? | **Requires improvement** |
| Is the service effective? | **Requires improvement** |
| Is the service caring? | **Requires improvement** |
| Is the service responsive? | **Inadequate** |
| Is the service well-led? | **Requires improvement** |

## Overall summary

Bluebird Care Southend & Rochford provides personal care and support to people in their own homes. Bluebird Care Southend & Rochford is part of a wider franchise network.

The announced inspection was completed on 14 January 2015, 16 January 2015, 19 January 2015 and 26 January 2015. At the time of the inspection there were 27 people who used the service.

A registered manager was in post. 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.

# Summary of findings

People told us that they felt safe however; staffing levels were insufficient to meet people's needs. Not all staff had received appropriate training to enable them to deliver care and support to people who used the service safely and to an appropriate standard. Formal arrangements were not in place to ensure that newly employed staff received a comprehensive induction.

Not all of people's healthcare needs were recorded and there were no instructions recorded for staff about how to meet these. People's care plans did not always reflect current information to guide staff on the most appropriate care people required to meet their needs.

The systems in place to deal with people's comments and complaints required improvement as there was little evidence to show how actions, decisions and outcomes of concerns raised had been addressed. In addition, we found that not all concerns or complaints raised had been logged.

The provider and registered manager did not have an effective and proactive quality monitoring and assurance system in place to ensure that the service performed safely and to an appropriate standard so as to drive improvement.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and to report on what we find. Information relating to people's ability to consent to their care and support was recorded within their care plan and where appropriate included the involvement of their relative or those acting on their behalf.

People told us they were treated with kindness and consideration by staff. Staff demonstrated a good knowledge and understanding of the people they cared for and supported. People told us that their personal care and support was provided in a way which maintained their privacy and dignity.

You can see what action we told the provider to take at the back of the full version of the report.

# Summary of findings

## 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 consistently safe. Appropriate steps had not been taken by the provider and registered manger to ensure that there were sufficient numbers of staff available to support people who used the service.

Appropriate arrangements were not in place to manage risks to people's safety.

Suitable arrangements were in place to ensure that the right staff were employed at the service.

The majority of people who used the service and those acting on their behalf told us they had confidence in the staff that supported them and they felt safe.

**Is the service effective?**

Requires improvement

The service was not consistently effective. Staff did not receive effective induction, training and appraisal, to ensure they had the right knowledge and skills to carry out their roles and responsibilities to an appropriate standard or to meet people's needs.

Not all of people's healthcare needs were recorded or met.

Staff received 'spot visits' and supervision at regular intervals.

**Is the service caring?**

Requires improvement

The service was caring.

Staff demonstrated a good knowledge and understanding of the people they cared for and supported.

People told us that they were treated with kindness and consideration by staff.

**Is the service responsive?**

Inadequate

The service was not responsive. People's care plans did not reflect current information to guide staff on the most appropriate care people required to meet their needs.

Care plans had not always been reviewed as changes in people's circumstances had changed.

The provider was not always responsive to people's care and support needs. We found that there had been delays in making referrals to other health and social care professionals.

Appropriate steps had not been taken by the provider or registered manager to ensure that people who used the service and those acting on their behalf could be confident that their complaints would be listened to, taken seriously and acted upon.

# Summary of findings

**Is the service well-led?**

The service was not consistently well-led. We found that the provider and registered manager had failed to implement a robust quality monitoring system that managed risks and assured the health, welfare and safety of people who received care.

The provider and registered manager had failed to recognise and identify inappropriate and unsafe care and support and; we had to point out the shortcomings in the service before actions were taken.

**Requires improvement**

# Bluebird Care (Southend & Rochford)

**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 14 January 2015, 16 January 2015, 19 January 2015 and 26 January 2015. The inspection was announced. The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available.

The inspection team consisted of one inspector.

We reviewed the information we held about the service including notifications received from the provider. This refers specifically to incidents, events and changes the provider and manager are required to notify us about by law.

We spoke with three people who used the service, seven relatives or those acting on people's behalf, nine members of staff, the registered provider, the registered manager and the care co-ordinator. We also spoke with three healthcare professionals.

We reviewed five people's care plans and care records. We looked at the service's staff support and recruitment records. We also looked at the service's arrangements for the management of medicines, safeguarding alerts, complaints and compliments information and quality assurance and audit information.

Requires improvement

# Is the service safe?

## Our findings

People were not protected against the risk of receiving support that was inappropriate or unsafe as there were not always enough staff to support people safely. Prior to our inspection concerns were raised that where people who required two staff to support them for personal care or manual handling techniques, there were occasions when only one member of staff had provided the support. Two relatives confirmed that for their member of family there had been several occasions when only one member of staff had attended to their family member's care and support needs instead of two. This meant one person could not be hoisted or moved for personal care to be carried out and they had to wait until the next visit by staff for their personal care needs to be attended to. The person's support plan showed that they had to wait for up to four hours until the next visit by staff for their personal care needs to be met. Another person would also not have received their personal care had it not been for their member of family available to assist staff with their manual handling and personal care needs. The relative told us they felt they had no option but to support staff at these times. The daily visit records for both people showed that there had been 10 and 11 visits respectively between the beginning of November 2014 and the beginning of December 2014 when only one member of staff had provided support to each person.

Staff confirmed that the above was a common occurrence. Comments included, "This happens many times." And, "There have been a few times when there has only been one member of staff to assist [person who uses the service] with manual handling and there should be two." Another said, "There are people who have not had sufficient staff to attend to their needs. [Relative] is suffering."

The registered manager told us that care was taken to ensure that people were well matched with staff to ensure they were compatible. The registered manager told us that in order to provide continuity of staff to people for their care and support needs, a 'core team' of staff was allocated to each person. People's and staff's comments conflicted with what the manager told us. One member of staff told us, "There is too many different staff going into customers' homes. There is no consistency of staff at times." Three relatives told us that their relative did not receive care and support from a 'core team' of staff.

We found that the registered person had not protected people against the risk of receiving support that was inappropriate or unsafe as there were not enough staff to support people safely. This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The majority of people told us they had confidence in the staff that supported them and they felt safe. One person told us, "I am confident that [name of person] is safe." Another person told us, "Oh yes, I am safe. I have no concerns." However, we found that appropriate arrangements were not in place to manage risks to people's safety. Where assessments were in place we found that these solely related to people's manual handling needs and environmental risks. Other risks relating to people's health and wellbeing had not been assessed. For example, where bedrails were fitted to help reduce the risk of falls for one person, no risk assessment had been completed detailing the actions to be taken to minimise the chance of harm occurring or in maintaining the person's safety. The records showed that in recent months the person had been found with their head trapped between the bedrails on several occasions. Staff told us that in recent weeks they had also found the person's head pressed up against the bedrails or between the pressure relieving mattress and bedrails. Staff told us that this caused a significant amount of distress to the person who used the service. Although information was available to show that in September 2014 the concerns as detailed above had been highlighted and the provider had written to a healthcare professional for advice, this had not been followed up. As a result of our concerns about this person we spoke with one healthcare professional. They told us that they would ensure further instructions were provided to staff to ensure that the person was kept safe.

One person told us that their relative had not always received all of their medication as they should and not in line with the prescriber's instructions. Records viewed showed that staff did not always complete the Medication Administration Records (MAR) as they should. For example, we found unexplained gaps on the MAR forms for three people and where a specific code was used to explain where medication was omitted, the rationale for this was

Requires improvement

# Is the service safe?

not recorded on the reverse of the MAR form.
Although staff had received medication training, some staff spoken with confirmed that they lacked competence and confidence in this area.

The staff training records showed that not all staff had received safeguarding training however, when we spoke with staff they were able to demonstrate a good understanding and awareness of the different types of abuse and knew what to do if safeguarding concerns were raised and which external agencies would need to be contacted.

Suitable arrangements were in place to ensure that the right staff were employed at the service. We found that the provider's recruitment procedure had been operated in line with their policy and procedure. We spoke with two members of staff and they told us that the interview process had been thorough.

Requires improvement

# Is the service effective?

## Our findings

Staff were not effectively trained and skilled enough to deliver care to people that met their needs and ensured their safety. One relative told us, "I do worry sometimes about staff's competence and abilities and there are times I have been concerned about [name of person's] safety as a result of this. I have brought this to the office's attention."

Training records confirmed that some training for staff had not been completed. For example, several members of staff told us they had not received practical manual handling training but were providing manual handling techniques to people on a daily basis. Staff told us that they were concerned about one staff member's poor and unsafe manual handling practices and advised that this had been brought to the manager's attention. Staff told us that they had observed them assisting people to move in a way that was unsafe and which put people at risk of harm and which did not meet their needs. At the time of our inspection there was no evidence that the manager had addressed the concerns raised by staff. The manager confirmed that practical manual handling training for this member of staff and others had not been completed but was due to be undertaken on 28 January 2015 and 5 February 2015. It was unclear as to why this had not been provided sooner. One member of staff told us that they had had to provide instruction and guidance to three members of staff on how to use a specific piece of manual handling equipment. They told us, "This is the responsibility of the manager."

One relative told us that they had made a complaint to the manager about two members of staff's poor manual handling practices which had resulted in them assisting their member of family to move in a way that was unsafe and put them at risk of harm. Following the inspection the provider told us that this had been raised by a member of staff to the manager. There was no evidence to show that either person had received practical manual handling training or that consideration had been given to bringing their training forward. They also told us that they were not assured that all staff who provided support to their member of family had the skills and competence to use the hoist properly.

Staff also told us they had not received training in key subject areas such as dementia awareness, managing people's anxieties, the administration of medication, pressure ulcer management and food hygiene. This showed that effective arrangements were not in place to ensure that staff were appropriately trained to meet people's needs and there was a risk that people would not receive the right care and support.

Although staff were positive about the opportunity to 'shadow' and work alongside more experienced members of staff, the provider did not have an effective induction programme in place. For example, one member of staff told us that if they had not had previous experience of working within a care setting, the induction provided by the organisation would not have enabled them to undertake their role to an appropriate standard. They told us that their induction was completed over one day and not two as originally communicated. Another member of staff told us they had completed their application form, interview and induction on the same day. A further member of staff told us that they had received their induction several weeks after they had commenced employment at the service and they felt that they lacked the skills to deliver care safely. Staff also confirmed they had not completed a formal and structured induction that allowed them to gain the skills to care for people safely and effectively.

We found that the registered person had not protected people against the risk of staff not being properly supported to provide care and support to people who used the service as they had not received an appropriate induction or training. This was in breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they received 'spot visits' and supervision at regular intervals. Although two staff employed longer than 12 months had not received an annual appraisal to review their overall performance, the manager provided an assurance that a system would be put in place for staff to receive an annual appraisal.

One person told us that they were able to independently request assistance from a healthcare professional so as to ensure their wellbeing. They told us if they needed support from care staff, they were assured that they would provide the appropriate assistance. We found that not all of a person's healthcare needs were recorded and there were no instructions recorded for staff about how to meet these. For example, we found that one person had a pressure ulcer. The person's care plan provided no information as to

Requires improvement

# Is the service effective?

the care and support to be provided by staff, how this was to be monitored and the additional support systems in place from external agencies such as District Nurse services. We found that concerns about this person's pressure ulcer were first noted by staff at the beginning of November 2014 however, the involvement of a healthcare professional was not apparent until the beginning of December 2014. This meant that although the person's healthcare needs had been identified, prompt referral to a healthcare professional had not been actioned to ensure that their healthcare needs were met.

Information relating to people's ability to consent to their care and support was recorded within their care plan and where appropriate included the involvement of their relative or those acting on their behalf. The majority of staff did not have a full understanding of the Mental Capacity Act (MCA) 2005 but confirmed they would refer to a team leader, the care co-ordinator or registered manager. Staff's training did not include MCA. This meant that they did not have sufficient knowledge and understanding of the main principles underpinning MCA, for example, promoting the best interests of the people they supported.

Where needed, people were supported to have enough to eat and drink and had their nutritional needs met by staff. People told us that staff supported them with meal preparation, provision of drinks and snacks and in some cases assisting people to eat and drink. Staff demonstrated a good understanding and knowledge of the support required to ensure that people had their dietary needs met. For example, a member of staff told us that one person's nutritional status had significantly declined in recent weeks. The member of staff told us of the care and support they provided to ensure that the person's nutritional and hydration needs were met at each of the visits provided by the service.

Requires improvement

# Is the service caring?

## Our findings

People and those acting on their behalf, told us that they were treated with kindness and consideration by staff. People were happy with the staff that supported them. The majority of relatives told us that the staff were kind and caring to their family member. One person told us, "The girls are lovely. They are excellent. I have no worries about the girls." One relative told us, "Two of the girls are absolutely lovely. I trust them completely." Another relative told us, "The staff are brilliant. This is the best care."

The registered manager told us that staff were given the opportunity to meet a person who was new to the service at the start of the care package being agreed. Although the majority of staff confirmed this, staff told us that this did not always happen in practice. Whilst staff demonstrated a good knowledge and understanding of some people's care and support needs, staff told us that they did not always get the time or opportunity to read through the person's care plan and risk assessments. One member of staff told us, "This is not great. This means that we do not always know the person's care needs before going to their home. We have to spend the first 10 minutes reading the person's care plan." One relative told us that although they met one member of staff who was due to provide care and support to their member of family prior to the commencement of the service, the member of staff did not have any information relating to this person's care and support needs. One staff member advised that they were not always given information by the office where a change to a person's needs had occurred and stated, "You do not always get to see the support plan prior to providing care. This is not right. You have to then spend time which the 'customer' is paying for, reading the care plan and not providing the care and support they need."

People told us that their personal care and support was provided in a way which maintained their privacy and dignity. They told us that the care and support was provided in the least intrusive way and they were treated with courtesy and respect. People told us that staff addressed them by their preferred name. Where appropriate staff told us they gave people privacy whilst they undertook aspects of personal care but ensured they were close by to maintain the person's safety.

Inadequate

# Is the service responsive?

## Our findings

The registered manager and care co-ordinator told us that people's care plans were written by them using the information gathered during the initial assessment period and prior to the service being agreed. Relatives told us they had been involved with their relative's care plan and contributed to the information recorded but only at the initial assessment period.

People's care plans did not always reflect their most recent or current needs. For example, the daily visit notes for one person recorded over a 23 day period that there had been 10 incidents whereby they had become anxious and distressed. The care plan did not consider the person's reasons for becoming anxious nor the steps staff should take to reassure them. The care plan did not provide staff with clear guidance about how to support the person at these times which meant there was a risk that the person was not receiving the care and support they needed or received care and support in an inconsistent way which could further escalate their anxieties.

Another person's daily visit notes showed that the person had a pressure ulcer. The care plan provided no information relating to their pressure ulcer and the impact this had on their health and wellbeing or that a healthcare professional had involvement. The person and their relative told us that this caused them significant pain and discomfort, resulting in them becoming anxious, distressed and reluctant to have their personal care needs attended to. This placed the person at risk of receiving inconsistent care and/or not receiving the care and support they needed.

In addition, the care plan had not always been reviewed as people's circumstances had changed. Staff told us prior to and during this inspection that they were concerned about one person's healthcare needs. Staff told us that the person's care and support needs had changed significantly in a short period of time and that little action had been taken by the management team to address this. Although their care plan had been updated in September 2014 and December 2014, no information was recorded detailing that they had two pressure ulcers and how this was being managed. In December 2014 the person experienced two falls. Although recorded in their daily records the care plan had not been updated to reflect this and how the person would be supported in the future. In addition, the care plan had not been reviewed and updated to reflect that the person's ability to drink independently had significantly declined and they required staff to assist them to drink. This meant that after the last visit at approximately 8.30pm each day by staff, they did not receive a drink until the following morning between 7.00am to 8.15am, a total of 10 hours. Staff confirmed that the person was unable to drink independently and relied on them for support. Although the manager confirmed that they were aware of the above information and had contacted a healthcare professional for advice, they had failed to follow this up and to review the existing care package so as to ensure that it met the person's needs and ensured their safety and wellbeing. A multidisciplinary meeting had not taken place prior to our intervention.

We found that the registered person had not protected people against the risk of receiving care or support that was inappropriate or did not meet their needs. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(1)(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People confirmed they were aware of the service's complaints procedure. They told us that they would not hesitate to discuss or raise any concerns with staff or the management team if the need arose. The provider had a complaints policy and procedure in place and this included a system for recording and responding to any complaints received. The systems in place to deal with comments and complaints required improvement as there was little evidence to show how actions, decisions and outcomes of concerns raised had been addressed. In addition, we found that not all concerns or complaints raised had been logged. Following our inspection we received information of concern telling us that the provider had not responded well to concerns raised. The complainant felt that the provider had not listened to their concerns or addressed them appropriately.

Requires improvement

# Is the service well-led?

## Our findings

Satisfaction surveys were carried out each year by the provider to gather people's views about the quality of the service provided and their experiences. The most recent survey had taken place in March 2014 and April 2014. The findings showed that eight surveys were returned and all comments received were complimentary. All rated the service with a score of either four or five, with five being the most satisfied. Comments included, "I'm very happy with everything. [Relative's] carer does above and beyond the call of duty" and, "Excellent care." However, at this inspection we found that although there were arrangements in place for assessing and monitoring the quality of service provision, these had not highlighted the areas of concern we had identified and was inadequate to ensure people's safety and welfare.

The provider did not have a system in place to check that records supported an effective management of the service so that people were protected. There was no audit of the care plans so as to ensure that accurate information was maintained and any areas of concern or issues that required attention were picked up and dealt with. The provider had no system in place to judge if staff were effectively supported and competent to carry out their role and responsibilities. The quality assurance system in place did not identify that people's needs were not being met. Overall, the quality assurance system was not effective at identifying areas for improvement.

The service did not have an open and transparent culture that encouraged staff to give their views of the service to improve the experience for people where needed. Not all staff spoken with felt supported by the management team. They told us that the manager and care co-ordinator were not approachable and there was not an 'open' and inclusive culture at the service. Many felt that communication was poor and that they did not feel valued and respected. Staff told us that they did not feel confident or able to question practice and decisions made at a management level.

The registered manager told us that staff meetings were carried out bi-monthly. They confirmed that the meetings were held in the morning and the afternoon on the same day so as to ensure that all staff were able to attend. Records of the meetings for 2014 were not available prior to July 2014. The provider advised that in addition to the above a memo was also given to staff at regular intervals detailing important information that they wanted all staff to read and be aware of. Actions to address the issues raised, to problem solve or drive improvement were not recorded.

We found that the registered person had not protected people against the risk of inappropriate or unsafe care, by means of an effective system to regularly assess and monitor the quality of the services provided. This was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where legal requirements 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<br><br>We found that the registered person had not protected people against the risk of receiving care or support that was inappropriate or did not meet their needs. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(1)(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>We found that the registered person had not protected people against the risk of inappropriate or unsafe care, by means of an effective system to regularly assess and monitor the quality of the services provided. This was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>We found that the registered person had not protected people against the risk of receiving support that was inappropriate or unsafe as there were not enough staff to support people safely. This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

This section is primarily information for the provider

# Action we have told the provider to take

| Regulated activity | Regulation |
| --- | --- |
| Personal care | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>We found that the registered person had not protected people against the risk of staff not being properly supported to provide care and support to people who used the service as they had not received an appropriate induction or training. This was in breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

This section is primarily information for the provider

# Enforcement actions

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