MyCapers Limited

Bluebird Care (Kensington and Chelsea)

Inspection report

76 Pembroke Road
London
W8 6NX

Date of inspection visit:
11 August 2016
12 August 2016

Date of publication:
28 September 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 11 and 12 August 2016 and was announced. This was the first inspection carried out for this location since it was registered in April 2014.

Bluebird Care (Kensington and Chelsea) is a domiciliary care service which provides personal care to people in their homes. This service is a franchisee of Bluebird Care run by MyCapers Ltd. At the time of this inspection there were 65 people using the service.

The service had a registered manager, who was on maternity leave at the time of this inspection. 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 being run by the Director and Deputy Manager in her absence.

The provider had recently deployed an electronic care notes system. This helped ensure that staff had detailed and up to date information on people's care needs, tasks which needed to be completed and medicines that people were taking. Using this system meant that care could be accurately recorded and monitored and audited in real time by managers, and relatives were also able to access this information. Care plans had detailed information about people's life histories, living arrangements and needs and preferences, and this information was reviewed regularly. People's nutritional and hydration needs were well recorded on plans, and staff ensured people had enough to eat and drink and recorded this in a way which could be easily followed by managers. There was evidence that appropriate consent was obtained to provide people's care and support.

Staff undertook extensive training on joining the service, and were required to attend refresher training regularly. Training was carried out by a dedicated training manager and staff obtained the Skills for Care, Care Certificate as part of their induction. Staff knowledge and skills were assessed as part of their training. In addition, there were frequent observations of staff practice made by supervisors, who regularly checked that people were happy with their care. Staff were well supported by managers who kept the team informed through team meetings and newsletters.

Care was usually delivered punctually, and we saw that there were good levels of consistency, which allowed people and their care workers to get to know each other well. People praised their care workers and felt that staff were kind and helpful and treated them with dignity and respect. There were examples of staff going beyond what was required of them to meet people's needs. There were detailed instructions on care plans to ensure that people's dignity was upheld, and staff spoke of how they ensured this took place. Complaints were recorded and appropriately acted upon.

There were procedures in place to ensure that staff were suitable to work with people, including carrying out Disclosure and Barring Service (DBS) checks, and assessing staff suitability as part of their induction and

probation. The provider was not always obtaining suitable references for staff. Plans were in place to ensure that risks to people's health and wellbeing were appropriately managed.

We found one breach of regulations with regards to obtaining references for new staff. You can see what action we told the provider to take at the back of the full version of this report.

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 safe in all respects.

Safer recruitment processes were in place, but the provider had not always taken up references for staff before they started work.

Staff understood their responsibilities to report where they had concerns that people may be being abused, and allegations and incidents were reported and investigated appropriately.

The provider had risk management plans in place for people. There were measures in place to ensure staff knew how to give medicines safely, and medicines were appropriately recorded and checked.

Is the service effective?

Good

The service was effective.

The provider had extensive measures for ensuring that staff had the appropriate knowledge and skills. This included regular training, written tests of people's understanding and regular supervision and observations of people's skills.

The provider had taken appropriate steps to ensure that consent was obtained for people's care in line with legislation.

There were systems in place to ensure that people had enough to eat and drink. Care plans had detailed information on people's nutritional and health needs.

Is the service caring?

Good

The service was caring.

People we spoke with were positive about their care workers, and said that they always felt respected and listened to. There was information on people's care plans about people's life histories and families.

Rotas showed that there was usually good consistency of staffing, and people told us their care workers knew them well.

Staff understood how to protect people's privacy and dignity, and there was information about this on people's care plans. Staff were assessed by managers for their communication and respect.

Is the service responsive?

Good

The service was responsive.

Care plans had detailed information about people's needs, preferences and wishes, and were reviewed regularly in response to changes in their circumstances. Care was recorded electronically by staff, which allowed managers to audit and monitor people's care on an ongoing basis. There was evidence of managers monitoring this and following up concerns.

Complaints were appropriately recorded by managers, who had undertaken investigations and taken appropriate actions in response.

Is the service well-led?

Good

The service was well led.

Managers carried out audits and had systems in place to ensure on-going monitoring of the quality of people's care. People's views about their care were sought through a yearly survey and regular monitoring visits.

Information about the service and staff responsibilities were communicated through team meetings and a regular newsletter to staff. Staff were well supported by their managers.

Bluebird Care (Kensington and Chelsea)

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 11 and 12 August 2016. The provider was given notice of this inspection because the location provides a domiciliary care service; we needed to be sure that someone would be in.

This inspection was carried out by one inspector with the support of an expert by experience, who made telephone calls to people who used the service and their families. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care 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 information we held about the service, including notifications of significant events that the provider was required to tell us about, and spoke with one contracts officer from the local authority.

In carrying out this inspection we made calls to 4 people who used the service, 6 relatives of people who used the service and 7 care workers. We also spoke with the director, deputy manager and training officer. We looked at 7 staff files including records of recruitment and computer files relating to the supervision, training and rostering of staff. We looked at 8 people's care files, and computer records relating to people's care plans, risk assessments, care visits and notes of care provided. We also reviewed 3 people's medicines records and looked at other information relating to the management of the service such as communication with staff and quality audits.

Requires Improvement

Is the service safe?

Our findings

The provider did not always follow safer recruitment processes to ensure that people were kept safe. Staff files showed that there was a process in place which required applicants to submit a full work history and proof of identification such as a passport and proof of address. Prior to starting work the provider carried out a check with the Disclosure and Barring Service (DBS). The DBS provides information on people's background, including convictions, in order to help providers make safer recruitment decisions. A checklist was in place which required the manager to sign off that all stages of the process were complete before starting work.

Despite the processes that the provider had in place, two staff files showed that the provider had failed to obtain references for candidates before signing off the recruitment process as complete. One care worker had been working for seven weeks, but had not provided references. The provider told us that this person had not worked in several years, but that they should have obtained a personal reference for this person. Another person who had worked for the service for six months had provided two references, which had been requested but not received by the provider and had provided a written personal reference. This was from a person who worked in a health service, but was not on headed notepaper and not addressed specifically to the provider. This reference contained a mobile telephone number, but the provider had not taken steps to verify the authenticity of this reference. This meant that the provider had not always taken the required steps to ensure that staff were suitable to work with people using the service.

The above issues constituted a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's internal audits, carried out in July 2016, had detected that some staff were working without suitable references and the provider told us they were taking action to rectify this. The provider had introduced an applicant tracking system in order to improve their recruitment process, and carried out psychometric testing to help ensure that people were suitable for their roles. The provider told us that their staff turnover figures were high, in part because some staff were not retained during the training and probation process because they were felt to be unsuitable for their roles.

People who used the service and their families told us that they felt safe using the service. Comments included, "My mother feels very safe with them in her home and so do we" and "They're reliable, they're there. If my mother had a fall or didn't answer the door to them I know they would report this immediately."

Staff had received training in safeguarding adults and children as part of their induction and were required to pass a written test to demonstrate their understanding of their responsibilities. Care workers we spoke with were able to identify the signs that a person may be being abused and their responsibilities to report suspected abuse. Staff were confident that their managers would take their concerns seriously and also knew how they could whistleblow in the event that they did not. Safeguarding concerns were being reported to the local authority and to CQC as required, and these were logged appropriately by the provider with evidence of how they had worked with the local authority to investigate these and take the appropriate

action. Where incidents and accidents had occurred, the provider had recorded these and taken action to reduce the risk of a recurrence, such as rotating care workers for a person who could become aggressive towards staff. The incident and accident log showed that these concerns were discussed with family members where appropriate. One person told us "Often at times they'll say 'your mother has a bruise' and that's very helpful as we can't check on these things as much as we would like to." One relative told us of a concern which hadn't been reported to them, and said "it would be much more helpful if they phoned me directly."

Risk management plans were comprehensive in their scope and met people's needs. The provider carried out regular assessments of the person's living environment, this included checking smoke alarms, hazardous substances, the suitability of lighting and the risk of the person falling. We saw that there were measures in place to check for food allergies and reduce the risk of cross contamination and scalding. There were risk assessments in place for people who may be at risk from moving and handling, for example, one stated that more than one care worker was required to safely lift the person and we saw that two care workers were being provided. Where a person was at risk of choking, we saw that there was a risk management plan in place, which required the person's food to be cut into small pieces and that they should be supervised when eating.

We looked at the records of three people who may have been at risk of pressure sores due to limited mobility. We saw that staff had carried out a risk assessment for one person, and had had discussions with other health professionals about how to manage these risks, including carrying out checks of skin integrity. For another person there was a risk management plan, which involved carrying out a weekly check of the person's skin integrity, although there was not a risk assessment in place at this point, which meant we couldn't be sure that this plan was sufficient. The provider had recently developed a new pressure care risk assessment, which they intended to put in place for each person. For another person with pressure care needs, we saw a detailed risk management plan, including changing the person on each visit, carrying out checks of skin integrity, and positioning the person using equipment such as sliding sheets. Skin integrity checks were scheduled on the staff rostering system, and supervisors had recorded that these had taken place. Staff had training in pressure care as part of their inductions and were required to pass a test demonstrating their knowledge.

Where equipment was provided to people such as frames and chairs, the provider had recorded that this equipment had been serviced appropriately, and had followed up issues with the supplier where there was insufficient recording of these checks. These were also checked by managers as part of their audit process.

The provider had a call rostering and monitoring system in place, and staff used dedicated mobile phones to log in and out from a person's home. The provider demonstrated how the system calculated the required travel time between visits, taking into account the person's mode of transport and average speed, and told us that this needed to be fine tuned when a person started with the service. Managers, including the out of hours on call manager, were notified automatically via email if a worker had not arrived for a call within 30 minutes.

People who used the service told us that their visits were "mostly" or "mainly" on time. We reviewed four weeks of call logging data for nine people, and found that on average staff arrived within one or two minutes of the scheduled time. There were calls when staff had arrived between 15-20 minutes late, but these did not happen frequently. Some staff told us that on occasions they did not receive enough travel time, but that this was not a frequent occurrence and usually happened as a result of emergency cover. One staff said "I don't like it when that happens, the latest I've been is 12 to 15 minutes late." There was no evidence of this happening on time critical calls

We also found that call durations were, on average, within a few minutes of people's allocated time, and that there was evidence that staff had stayed longer on occasions. For one person, there was evidence of staff leaving calls up to 20 minutes early, which the provider told us was due to being asked to leave early by the person's family. We noted that staff had not recorded in the log when this had occurred, and the provider told us they would ensure that this was recorded in future.

The provider had measures in place to ensure that people received their medicines safely. Staff received mandatory training as part of their inductions on administering medicines, and the provider required staff to demonstrate their learning through a written test. This training was refreshed yearly, and we saw examples of some of the tools such as blister packs which were used in these sessions. Staff received regular observations of their competency by supervisors, which assessed whether staff were checking medicines packages against records, whether the person was prepared appropriately, and whether medicines were being stored in line with the person's care plan.

Medicines were recorded as tasks to be completed on the electronic care notes system. This meant that care workers could access medicines information on their smartphones, including dose, time and frequency and used this system to record the administration of medicines. We reviewed records for three people, and saw that this was being used appropriately. Staff had also recorded when a medicine had not been given and the reason why, such as a medicine prescribed "as required" not being needed that day, or a course being finished or a medicine being changed. When this happened, or if a medicine was missed altogether, supervisors received an alert on their computer systems which allowed them to take prompt action, and we saw that managers had recorded that they had taken action. The provider told us that they used this system to ensure that changes to medicines could be immediately recorded on the care plan. Care notes showed that checks on the person's medicines were being carried out at least fortnightly by a supervisor.

Care plans were clear about where the responsibility for a medicine lay between the provider, the person using the service, their family and other agencies. There was evidence of the provider following up with health professionals where there were medicines queries.

Good

Is the service effective?

Our findings

People were supported by staff who had the skills and knowledge to meet their needs effectively. As part of the induction programme, staff undertook a five day training programme based on the Care Certificate. This included an introduction to the company, understanding the role of a care worker and personal development, duty of care, equality and diversity, person centred care, awareness of mental health, dementia and learning disabilities, safeguarding children and adults, life support, handling of information and infection prevention and control. There were modules related to health and safety, which included fire safety, medicines and safer moving and handling. There was a training officer who ran these courses in a dedicated training room, which included moving and handling equipment for training staff in their use.

On completing a training course, staff were required to complete a test to demonstrate their learning, and were not recorded as having completed the training until they had passed this test. We saw evidence that some staff had failed these tests and had been required to retake. The staff rostering programme recorded when staff had completed this training, and this included the date when this training expired and needed to be repeated. For example, safeguarding training was repeated yearly, and medicines training six monthly. We saw that staff had received up to date training in all areas required by the provider.

Staff told us that the training was helpful and of a high quality. Comments included "Everything was covered in the induction, and there wasn't anything missing" and "It was very good, very thorough" and "They do mini exams to make sure it's logged in your head."

New staff underwent a programme of shadowing and assessment and agreed their probation goals before starting their probation periods, and had weekly supervision during this time. The provider told us that they considered the trainer to be a gatekeeper, and they used this process to ensure that people without the correct skills and values did not go on to work with them. The provider had a high turnover of staff, which they attributed in part to people not successfully completing the induction and probationary process.

Staff confirmed that they received monthly supervision. The provider told us that supervisions were usually rotated between telephone supervision, face to face supervision and observations, and records confirmed that these were taking place. One person told us "They do spot checks on the carers, they pop in often and check that all's being done, which is very good." Staff told us "They come and assess us while we're working" and "They pop in to see if you are wearing your uniform and how you are doing." Observations of staff competency required supervisors to assess a staff member's timeliness, appearance, their approach to people and food safety and infection control skills. Supervisors checked whether the worker had consulted the support plan, adhered to health and safety guidelines, treated the person with dignity and respect and communicated with the person in the way they would like. They recorded whether the person was satisfied with the care worker.

Supervisions with staff involved discussing whether they were appropriately supported, whether they thought care plans reflected people's needs and required any changes, and whether there had been recent changes with medicines. Staff also discussed whether their rotas were suitable, if they felt listened to and if

they had any concerns.

The provider was meeting its responsibilities under the Mental Capacity Act. The Act 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 had signed to indicate their consent to their care, and for one person there was evidence of an assessment being carried out of their capacity and that the provider, family and social worker were demonstrating that they were acting in line with their best interests. Care plans recorded where a person had a Lasting Power of Attorney in place, and where appropriate the care plan had been signed by this person. In two cases people were recorded as being unable to sign or had not signed without an explanation of why. The provider explained that these people still had capacity to consent to their care plans, but were now physically unable to do so due to infirmity. This had been noted in audits.

People told us that the provider made sure they always had enough to eat and drink. One person said "She always asks if I want a cup of tea or anything to eat." Staff had received training in nutrition and hydration, and one staff member said, "We have to make sure we leave fresh fluids before we leave." Managers had used tools such as the staff magazine to ensure staff remained aware of the risk of dehydration in warm weather.

Where required, charts of food and fluid intake were in place. These were now recorded on the electronic system, and included details of what food groups were eaten and at what times. There were risk assessments in place where people were at risk of malnutrition. Where it was part of people's care plans that staff support them to eat, there were measures in place to ensure staff had recorded whether this was done or why they hadn't, for example that food had been refused or the person had already eaten. Care plans included a requirement to offer each person a drink, and staff had recorded what they had offered, whether the person had fluids in place when they had arrived and whether they were left with fluids. Staff also recorded the reasons why they had not completed this task. If any of these tasks were not completed, for any reason, they appeared as an alert on the manager's computer, and the manager had to verify that they were satisfied with the outcome of this.

Care plans included detailed information on people's medical conditions and histories, this included details of any diagnosis they had, and information to help staff to understand the condition. There was evidence of staff liaising with other professionals such as district nurses if they had concerns about people's health.

Good

Is the service caring?

Our findings

People who used the service and their relatives were very positive about their care workers. Comments included "She was very sweet", "they even clean [the bathroom] for me, and they don't have to, and after they are done it is gleaming", and "they're very good, they do listen."

One relative told us "They all know Mum, they work and they care for her. They're always chatting away with her when washing and dressing her" and another said "They wash my relative once a week…this is a very big deal as she won't let anyone, so for [her carer] to be able to do that for her is a big thing!" Another person said "Oh yes, they always listen and are very respectful" and one person said "If I am sleeping they leave me, they don't bother me." A relative told us "She always fills us in on what they're up to, so we know they're engaging with her."

Care plans contained information about people's life histories, family, likes and dislikes and their preferences with their care. The provider told us that they tried to ensure that people were allocated staff who were compatible with them. We saw that staff were assessed regularly by supervisors for the quality of their communication and the respect that they had shown the person. Care plans also contained information on people's communication needs, such as requiring glasses to read.

The provider had recently moved to an electronic care notes system, which allowed care notes to be viewed from the office, but also for families and health professionals to be able to access up to date information on the person's care and condition. There were instructions on the front of people's care folders for how people could do this. We saw that some family members had started to use this system, which also allowed them to pass messages on to staff. The system had not yet been fully adopted, and one family member told us that they had found it difficult to set up the system, which required downloading a smartphone app.

Rotas showed that staff were consistently allocated to people. This allowed people to form good relationships with staff. In some cases only one care worker ever worked with the person, and in one case where a person received several visits a day, this was covered by only three workers. One relative said "What's nice about Bluebird is that they try to have the same carers, as my mother does get confused." We saw evidence that when a preferred member of staff wasn't available people were given the choice between changing their visit times or having a different carer; the person had chosen to change their visit time. In another case, a carer had visited for an introductory visit, and a manager had recorded that they had spoken with the person, and that they were very happy with the care worker and wanted to have them as their regular carer, and rotas showed that this was taking place.

Care plans also contained information about people's bathing preferences, such as how they wanted to be bathed and what carers they preferred. Written into the care plans were instructions on how to protect the person's privacy and dignity, such as ensuring that the person was covered by a towel whilst carrying out personal care. All staff we spoke were able to explain the steps that they took to ensure people's dignity was respected. One staff said "We make sure we've covered them properly and speak to them politely, and let them know what we're doing at a particular time, and are they happy with it." Another staff said "We follow a

certain procedure, including closing the curtains when we are performing care, and always speak to the person and ask them before doing anything."

Good

Is the service responsive?

Our findings

People told us that care was person centred and responsive to people's needs. Comments included "They are very accommodating" and "it's really helping [my relative] get her confidence and independence back."

Care plans were recorded using an electronic care notes system. This used information from a person's assessment to identify a person's required outcomes, and broke these outcomes into a series of tasks. For example, when the outcome was to help a person maintain their personal hygiene, a task may be to support somebody to have a bath or to have a strip wash, or to check their pad. The care plan then allocated these tasks to particular visits. Care plans included details on people's living arrangements and support that they needed to maintain their safety. There was also information on what domestic tasks were required to be done by staff.

There was detailed information on people's independence in many areas of daily living and what support people required to maintain or increase their independence. For example one plan stated that the person was extremely independent and could do most things for themselves, but then contained detailed information on the areas that they needed support with. One relative told us "[my relative] has always been independent and they do help her to keep that way."

Staff told us they thought these contained enough information to allow them to carry out their roles. One staff said "I don't think there's anything missing ever from the care plans, and if there is we get the time to call and tell them about it." Staff told us that they had been given smartphones which allowed them to access the most recent care plan for the person; this allowed them to see up to date information on the person's care needs and their most recent support.

The provider told us, "our care plans are always a work in progress, we look at notes and talk to carers as people get to know us." The system recorded evidence that plans were reviewed regularly, and changes made based on changes in people's needs. Care plans we looked at had been reviewed and altered at least three times in seven months. Managers told us that in the event of change, for example with medicines, they were able to enter this in the plan quickly and easily, and the system automatically relayed changes to the care workers through their phones. Managers were also able to suspend a task, for example if a medicine had been stopped, or if the person had gone into hospital, which also showed up on staff phones. A staff told us "I will ring up and say if something different needs to be in the care plan, then they will come out and assess and make the changes."

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Staff told us they thought care plans contained enough information to allow them to carry out their roles. One staff member said, "I don't think there's anything missing ever from the care plans, and if there is we get the time to call and tell them about it." Staff told us that they had been given smartphones which allowed them to access the most recent care plan for the person; this allowed them to see up to date information on the person's care needs and their most recent support.

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When staff had completed a task, they would mark this as complete on their phone, and if a task had not taken place, they would record the reasons why. For example if a person had either a bath or a strip wash, one task would be marked completed and the other would marked as not required. This also allowed staff to quickly record that drinks and food had been offered if this was part of the care plan. Staff also wrote a brief free text description of exactly what care had been provided. We saw that there were tasks marked as not completed, with a satisfactory reason given which had been signed off by a manager. This meant that the notes were more likely to accurately reflect the care and support given. One staff member said "I find it much quicker and easier."

We also saw that in the event of a task not being completed, managers received an alert on their computer system, and had to sign off that they were satisfied with the reason given by the staff member for not completing the task. Staff we spoke with told us that managers followed up anomalies on care notes, one person said, "Yes they do follow up, I have certainly experienced that." This meant that managers were able to monitor the completion of notes on an ongoing basis, rather than relying on periodic audits, and that missing tasks could be followed up promptly.

We saw evidence of people complimenting the service they had received. One note thanked the service for arranging the repair of a person's recliner chair the same day it had been broken. The provider told us that the person would have been at risk otherwise, so they were able to contact the supplier and arrange an urgent repair. A manager told us about a time a person had left their wallet in a taxi, and they had made calls in order to trace it. Compliments included '[My family member] was well served' and 'wonderful, kind and very helpful, certainly the best.'

People told us they felt their concerns were taken seriously by managers. One person said "There have been times when we've said we can't have that carer and that's been fine, they listen and they respond." Another said "There have been times when I've had concerns but I feel free and able to speak to them about it. But they are a good agency, they always have been."

We saw that the provider had systems in place to ensure that complaints were appropriately logged, investigated and outcomes of complaints were recorded. A complaints document recorded the name of the person complaining, a summary of the complaints and how the provider had responded. For example, one person complained about the conduct of their care worker, this was investigated and the staff spoken with, and the person was given the option of continuing with their care worker or having a different staff member. In another case, we saw that the provider had investigated a member of staff's conduct following a complaint, and were dismissed as a result.

Good

Is the service well-led?

Our findings

People who used the service told us they knew who the manager was and that they were asked for their views. One person said "It feels like a very good set up."

Staff told us that they felt well supported by their managers and their colleagues. One person said "The staff are very supportive if you have any problems", and another said "They're a good management team, really lovely, easy to get on with, they do tend to help you if you get stuck. It's a pleasant place to work." Another staff member said, "My concerns are dealt with quickly as and when they arise."

The registered manager had been on maternity leave since September 2015. The provider had recruited an interim manager, who had registered to manage the service in her absence, however this person had recently left the service, which was now managed by the director and deputy manager on a temporary basis. The director was very visible in the service and with communications with staff. The provider was meeting its responsibilities to notify CQC of safeguarding concerns and significant incidents which had affected the service.

We saw that a weekly meeting was held every Monday in order to review specific incidents that had occurred in the past week, including anything recorded by the on call. This also included a review of risk assessments, incidents and accidents and any missed or late visits or medicines errors. They also discussed changes in people's needs and hospital admissions. The provider told us that senior managers then met in order to analyse this information and detect trends.

Care workers meetings also took place regularly, staff were rostered to attend, and several meetings were held in order to ensure that everyone had the opportunity to attend. Staff were paid to attend these meetings. The agenda for these meetings was set by the supervisors, and took account of what was going well in the service and what could be going better. Topics discussed in these meetings included use of the computer system and logging in and out, communication with the office, use of the out of hours system, punctuality and the conduct of staff. Managers also discussed the requirements for refresher training, uniforms and ID. We saw that all staff were issued with photographic ID. The provider told us that certain subjects such as confidentiality were discussed yearly, and other topics such as staff availability and their choice of shifts were discussed as the need arose.

We saw evidence that efforts by managers to bring about changes had been effective. For example, staff had been reminded through team meetings about the use of the call logging system. This had improved from 90% in May to 94.31% in July, which was just short of the provider's target of 95%.

Communication with staff was aided by a monthly staff newsletter, which was delivered electronically to all staff. This included information on a featured care worker, and provided information for staff on areas such as oral hygiene, and the risks of dehydration for staff and people who used the service. In response to particular incidents staff were reminded about the provider's policy, but the director explained "We have tried to make it a positive reinforcement."

The provider also ran a care worker of the month scheme, and we saw photographs of staff who had received this award displayed in the office alongside a quote from them about what they valued about their role and the service. Staff also received long service awards when they passed certain milestones, and these were advertised in the staff newsletter. There was also a referral scheme, whereby staff were paid a bonus if they encouraged somebody they know to work for the service, which was payable when this person passed their probation.

The provider had measures in place to judge people's satisfaction with the service. A survey had been carried out last September, and about a third of people had responded. This showed that 82% of people said their care workers were punctual. All respondents had said that their care workers were polite, considerate and treated them with dignity and respect. Two-thirds of respondents had said that they knew who to contact, but everyone had said they were comfortable raising concerns with the office. We saw that managers had redesigned this survey for this year, and further questions were asked about the quality of care people received, and whether their nutritional needs and preferences about their care were met. In addition to this, people's views on their care workers were regularly sought through monitoring visits.

We saw that when a person had become aggressive to a member of staff, staff wrote a factual statement about the incident, but were also asked to write a personal statement on how they felt, whether they were able to continue supporting the person and any further support managers could offer. Staff appraisals were carried out yearly for all staff, and recorded care worker's key strengths and accomplishments, any issues that had arisen, and rated people's team work and skills and identified any areas for development. We saw evidence that where poor practice was identified, the provider had formally investigated this and where necessary had instigated disciplinary proceedings.

The provider told us that they had worked with HM Revenue and Customs (HMRC) to complete an audit to ensure that they were paying staff the London Living Wage (LLW). Staff were not paid for travel time, but the director explained that the rostering system automatically calculated a worker's average wage, and paid a top up in the event that this fell below LLW levels.

Audits had been carried out recently of care and employee files. We saw that these were comprehensive and detailed in their scope, and had highlighted areas such as missing signatures on care plans and gaps in employee files, including when there were not references in place. The use of an electronic care notes system allowed care delivered to be monitored and recorded on an ongoing basis. There were also external audits carried out by Bluebird Care's franchise support centre, and an action plan was drawn up in response to this. For example, this identified that call monitoring compliance needed to improve, that staff needed new phones to successfully use the new care notes system, and that a new applicant tracking system was required to aid the recruitment process, and these actions had been put in place by managers.

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 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not operated recruitment processes effectively to ensure that persons employed were of good character. 19(1)(a), 2)