Verafrank Aji Limited

Bluebird Care Newmarket and Fenland

Inspection report

Unit 1, March Enterprise Park
Thorby Avenue
March
Cambridgeshire
PE15 0BD

Tel: 01354704500

Date of inspection visit:
12 December 2016
14 December 2016

Date of publication:
22 December 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Good
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

Bluebird Care Newmarket and Fenland is registered to provide care to people living at home. People using the agency have a range of physical and mental health needs. The agency provides care to people who live in neighbouring towns and villages. At the time of our inspection there were 42 people using the agency and there were sixteen care staff employed to look after them.

This comprehensive inspection took place on 12 & 14 December 2016 and was announced. It was carried out by one inspector.

The provider is required, as part of their registration, to have a registered manager. A registered manager was in post at the time of our visit. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage a registered service. 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.

People were kept safe because staff were knowledgeable about reporting any incident of harm. There were enough staff to support people with their individual needs. Pre-employment checks were completed so that only suitable staff looked after people who used the agency. People were supported to take their medicines as prescribed or were enabled to remain independent with this part of their care.

People were helped to be independent with eating and drinking and people took sufficient amounts of food and drink to keep them well. The nature of the care promoted and maintained their well-being and reduced their sense of social isolation. People were enabled to remain independent with making their own health care appointments.

The CQC is required by law to monitor the Mental Capacity Act 2005 [MCA 2005] and the Deprivation of Liberty Safeguards [DoLS] and to report on what we find. At the time of our inspection no person was assessed to lack capacity. Staff members had some understanding of the application of the MCA. The provider had some awareness of the actions to take if a person required a DoLS application to be made.

People benefited from being looked after by staff, who were trained and supported to do their job.

Staff treated people in a kind and caring way. People were actively consulted about their planned care. General advocacy services were not being used at the time of our inspection although the provider was aware of the availability of such services.

People's individual health and social care needs were met. Staff had up-to-date information which enabled them to provider the right level of care to meet people's assessed needs. There was a process in place so that people's concerns and complaints were listened to and these were acted upon.

There were management arrangements in place which helped care staff to do their job. Staff were supported and managed to look after people in a safe way. Staff, people and their relatives were able to make suggestions and actions were taken, if these were needed. Quality assurance systems were in place to ensure that people were kept safe and well.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were sufficient staffing numbers so that people's needs were met.

Recruitment systems were in place so that only suitable staff looked after people.

People's medicines were safely managed.

Is the service effective?

Good

The service was effective.

People were able to make informed decisions about how they wanted to be looked after on a day-to-day basis.

Staff were trained and supported to enable them to meet people's individual needs.

People's health and nutritional needs were met.

Is the service caring?

Good

The service was caring.

People were looked after by staff who were kind and caring.

People's rights to independence, privacy and dignity were valued and respected.

People were involved and included in making decisions about how they wanted to be looked after.

Is the service responsive?

Good

The service was responsive.

People's individual needs were met in line with their planned care which was kept under review.

People's care enabled them to remain living at home.

The provider had a complaints procedure in place which enabled people and their relatives to raise concerns.

Is the service well-led?

Good

The service was well-led.

People and staff were enabled to make suggestions to improve the quality of the service provided.

The provider operated an open culture in the management of the service.

Quality assurance systems were in place which ensured that people were being looked after in a safe way.

Bluebird Care Newmarket and Fenland

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 agency, and to provide a rating for the service under the Care Act 2014.

This inspection took place over two days which was on 12 & 14 December 2016 and was announced. It was carried out by one inspector.

The provider was given less than 24 hours' notice because the location provides a domicillary care agency; we needed to be sure that someone would be as we did not want to impact on the training the provider had already arranged for their staff.

Before the inspection we looked at all of the information that we had about the agency. This included information from any notifications received by us. A notification is information about important events which the provider is required to send to us by law. Also 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 agency, what the agency does well and improvements they plan to make.

On the first day of our inspection we spoke on the telephone with three members of care staff; four people who used the agency, and two people's relatives. During the second day of our inspection we visited the agency office where we spoke with one director; the registered manager; one supervisor and one co-ordinator. We looked at four people's care records; audits; minutes of staff meetings and records in relation to the management of staff.

Good

Is the service safe?

Our findings

We checked and found that arrangements were in place to keep people safe. The provider told us in their PIR that, before staff looked after people, they were trained in safeguarding people at risk. We found evidence to support this statement: staff members were aware of their roles and responsibilities in keeping people safe from harm. They were trained in safeguarding people at risk and were able to demonstrate their knowledge about this. Members of care staff were able to demonstrate the different types of harm and said that they would report such untoward incidents if needed. One member of care staff said, "I would report it first to my [registered] manager. If it was immediate, I would report it to social services. Or even the police." They were also able to tell us how they would know if someone was being harmed. They said, "If it was physical there would be marks. You would also find hidden marks when doing personal care. Or a change in their demeanour." Training records showed that staff had attended training in safeguarding people at risk. The provider had sent us notifications which provided evidence that they had followed the correct safeguarding actions and reporting procedures.

Only staff that were suitable were allowed to work for the provider. The provider told us in their PIR that staff were subjected to recruitment checks before they were considered suitable to work. This included, "… a DBS check and a minimum of 2 previous employer/character references which are fully validated by our business before care can be delivered." One member of care staff said that they had undergone recruitment checks, which were carried out before they started to look after people. They told us, "There was a CRB [Criminal Records Bureau] check which I think is now called a DBS [Disclosure and Barring Service police check]. I had two written references. One from my previous employer. I filled out a form with my personal details and my previous work experience. It was an application form. I had telephone interviews over two days before I came in for my induction training." Another member of care staff also told us that they had the required checks carried out before they were allowed to start looking after people who had care provided by the agency. Staff recruitment files contained all the required checks and these were carried out before members of staff were allowed to work.

The provider had a staff disciplinary procedure in place which was used in the event of staff failing to meet the [provider's] standards expected of them.

People were looked after by sufficient numbers of staff to meet their needs. Both people and members of care staff said that there was enough staff. Measures were in place to cover unplanned staff absences. One member of care staff said, "Shifts get covered" by other members care staff. The co-ordinator told us that there was always sufficient staff to look after people. In the event of unplanned absences they said that, "The office [based] team would help out."

We found that people were kept safe as much as possible by means of assessing and managing their risks. The provider told us in their PIR that, "When a customer [person who uses the service] approaches us for support we carry out an initial assessment which includes comprehensive risk assessments. The risk assessment process is to gauge potential risks to the customer, staff and others around them. This also allows for us to work safely with the customer and mitigate any potential risks identified." One member of

care staff told us that people's risks were assessed when they were to start having the care. They also gave examples of the types of risks that people were assessed to have. These included risks associated with moving and handling and described the measures that were in place to minimise such risks. People's moving and handling needs were carried out by trained staff. In addition, two members of staff were used if hoisting equipment was to be used. People's care records showed that more than one member of care staff helped people with their transfers by means of hoist equipment.

Other risks were associated with the security and safety of people's homes. Two people told us that they were satisfied with how staff kept their homes secure with the use of a key safe. One person said, "When they [care staff] go they lock the door behind them and put the key back in the safe." One member of care staff told us, step-by-step, how they ensured people's key codes were kept secure. This was so that no unauthorised person was able to access the door key from the key safe. The process included "scrambling" the numbers of the key code when the key safe was not in use. Another member of care staff told us about the risks of people tripping and falling. Assessments were carried out for external and internal premises of people's homes. They said that if any hazards were identified, such as an unsafe condition of a rug, they would inform the office staff who would manage the situation.

People were protected from the unsafe management of their prescribed medicines. The provider told us in their PIR that staff were trained and were assessed in the management of people's medicines because, "Medication competency (is) completed every 3 months." Members of care staff said that they had received the training in managing people's medicines. They also told us that they had been assessed to be competent at least every three months. Staff records confirmed that this was the case.

Members of care staff were aware of the procedure to follow in the event of people not taking their medicines as prescribed. One member of care staff said, "If the person continues to refuse to take it [prescribed medicines] we inform the office [staff] and someone will go and reassess the person." The director confirmed that this was the process that staff would take. Members of care staff and the registered manager told us that the use of covert [hidden] use of medicines would be used if it was based on a 'best interest' decision. They told us, however, that the use of covert administration of medicines was not currently practiced. People told us that they were independent with managing their own medicines. When people needed help with taking their prescribed medicines, staff had the care plan guidance in how to assist people with this. The records showed that there were satisfactory systems in place for people to receive and dispose of their medicines. Medication administration records showed that people were helped to take their medicines as prescribed.

Good

Is the service effective?

Our findings

We checked to see how people's rights were being protected. The Mental Capacity Act 2005 [MCA] provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in registered services are called the Deprivation of Liberty Safeguards [DoLS]. We checked whether the agency was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager advised us that at the time of our inspection none of the people lacked full mental capacity. Recorded evidence indicated that people were able to make decisions about their day-to-day care. In the event of a person requiring an authorised DoLS the registered manager told us that they would seek advice from their organisation. We 'sign-posted' the registered manager to a dedicated local authority DoLS advisory team. This was so that they had an increased awareness of available support in regard to DoLS applications and the role of the Court of Protection in authorising such applications.

One member of care staff said that they had attended training in the application of the MCA and demonstrated an understanding of this piece of legislation. They said, "It [MCA] is that you can't assume people lack capacity unless proven otherwise. If decisions are made, then it's in their best interest." They told us which people would be included in making such best interest decisions, and these included legally appointed people. However, this level of knowledge was not always consistent among other care staff who we spoke with. Nevertheless, they were aware of respecting people's choice. One member of care staff said, "People [living with dementia] like routine and do take their medicines. If they refuse we can't force them." Another member of care staff described how they offered people choice so that they were able to make decisions about what they wanted to eat and what clothes they wanted to wear. The registered manager and director were aware of the shortfalls in staff members' understanding of the application of the MCA. As a result staff training in the MCA was arranged to take place during 2017.

We found out that staff were supported to do their job. The PIR told us how the provider aimed to support staff by "…regular supervisions and reviews (to) ensure that we are working together as a team and that the service we provide remains effective." Staff told us that they felt supported to do their job. One member of care staff said, "They [office staff and management team] are always very supportive. You can ring the office or on-call [manager] and they'll always help you. They are very fair and it's a nice company [provider] to work for." Another member of care staff said that the members of the team of staff worked well together and this helped with the support of each other.

We found that staff were effectively trained to do their job. People told us that they had confidence in the

ability of staff to look after them. One person said that, although they did not always receive care from the same staff members, they had confidence in the ability of all staff. This included staff members who were new to them. Another person also had similar views and said, "I don't have to say do this or do that. They [all care staff members] know what to do."

One member of care staff said that their four-day induction training was, "Really good. They [trainers] take you through a lot of things. Such as moving and handling and things about the organisation [provider]." In their PIR the provider wrote, "All staff have a full induction at the beginning of their employment into their role as a Care Worker and Bluebird Care the company, which is then certificated to evidence successful completion." Staff records confirmed that staff had attended induction which included training and 'shadowing' other members of care staff.

The provider also told us in their PIR that, "We ensure that all employees training is refreshed annually." Members of care staff told us that they had the training to do their job and listed the types of training that they had attended. These included, for instance, emergency resuscitation; moving and handling and dementia care. One member of care staff said that the dementia care training had enabled them to gain more insight into the experiences of people who were living with dementia. They said that they had become aware of giving people reassurances when they became unsettled. Another member of care staff gave an example of how they had applied their dementia training into practice. They described how they had contributed, with the person's relatives, in helping a person to come to terms with a personal bereavement. The member of care staff told us how this help had made the person become more settled. In addition, the help had empowered the person to develop and use their own strategies to deal with their bereavement. This told us that staff were trained to ensure that people's needs were safely and individually met.

We checked to see how people's nutritional needs and choices were being met and valued., One person told us that they were independent with eating and drinking but said, "They [care staff] always ask if I want a cup of tea or coffee before they go." One member of staff said that they helped prepare people's food which they were independent with eating and drinking. Another member of care staff told us how they offered people, who were living with dementia, a choice of what they wanted to eat and drink in a way that they were able to understand. This included a small range of options of three different meals for people to be able to successfully choose from. People's care records demonstrated that people were helped to take sufficient amounts to eat and drink. The coordinator gave an example of when a person was not eating or drinking enough. Their care plan was revised so that staff would sit and talk to the person while they were eating their meal. The coordinator told us that the change in the person's care plan had worked as the person was now eating and drinking enough.

We found that people's individual health needs were being met. One person said that they were independent with making their own health care appointments. Another person also told us the same. They said, "I only have to pick up the 'phone and ring the doctor and someone comes." The nature of the care enabled people to remain at home. One person said, "I am happy being in my own home. I don't want to be sitting in a care home. Here I can do what I want to do." One relative - who was the main and only carer for their family member - said, "[Name of family member] has care every morning and it's a big break for me. It takes the responsibility away from me." The provider had received compliments from people. One of these read, "I really look forward to seing (sic) them [care staff]. My family [relatives] have seen a difference in me. I am more happier." Another of these read, "[Name of person using the agency] wanted it to be known how much [person] appreciates all of the care, support and companionship given to [person] by all of the care team who attend [person's] needs."

Good

Is the service caring?

Our findings

We found how staff looked after people and we received a number of positive comments about their experiences. One person said, "The nurses [care staff] are absolutely fantastic. They all deserve a medal." Another person said that the staff were kind and, "Always ask if there is anything else I want before they go." One relative told us that the care staff were "very polite" to them and to their family member. They also told us how their privacy was respected. They said, "The staff always ask if they can go into our bedroom to get [name of family's] clothes." Another relative said, "We are more than happy. They [care staff] are a great lot. We can have a joke and a laugh. And they are all polite." We found that people were looked after by caring members of staff. One member of care staff said that the purpose of their job was, "To keep people safe and look after their well-being." Another member of care staff said, "I love my job. Looking after people so that they can be safe and stay living at home."

People told us that their privacy and dignity were valued. One person told us that they only had female care staff to provide them with their personal care. Another person also told us the same and said, "I wouldn't want anything else." They added, however, that they wished to have the same 'regular' staff. They had 'regular' care staff during the morning calls but not so 'regular' care staff during evenings and at weekends. One member of care staff said that, when they looked after the same people, they came to know what they liked. They said, "I see 'regular' people. It's really important for them to see the same faces. You get to know how they want you to be with them. It builds up [their] trust and confidence."

The provider told us in their PIR that, "We ensure that the staff understand that we are there to support our customers [people who uses the agency] to enable them to be as independent as possible and not take over their lives. We regularly speak to and visit our customers to ensure that they are receiving care that prompts us as a caring agency and that we understand their needs, wishes and preferences. We take our time to listen to their needs, wishes and preferences." People told us that staff knew about how they liked to be looked after, which included how they wished to be referred to. One person said that they liked the staff to call them by their first name. They told us that it was a "more friendly" mode of address.

People were involved in the development and agreement of their planned care. They told us what times they were due to have the care and when. One person said, "I get a call each morning and evening." One relative said, "They [care staff] come very morning. Usually about 8am." The registered manager and director told us that people's wishes of the times when they wanted to have their care were taken into account when setting up the initial care plan. Care records showed that people's choices, of when they wanted to have their care, were accommodated as reasonably as possible.

The registered manager advised us that none of the people required representation from general advocacy services at the time when we visited. However, the director was aware of the charitable organisations who offered this type of service. Advocacy services are independent and support people to make and communicate their views and wishes.

Good

Is the service responsive?

Our findings

We found that people's needs were met. One person said that they had help with their personal care during which members of care staff "thoroughly" dried them, after having help with taking a bath, and helped them to get dressed. Another person told us that the care met both their physical and social care needs. They said, "Sometimes when I feel a bit under the weather, it doesn't really bother me because I know the nurses [care staff] are coming in. I'm grateful for them coming in twice a week. I live on my own so it's nice to have a bit of company." A third person told us that the staff made sure that they had access to their walking aids. This was so that they remained independent with their mobility and increased their levels of confidence in walking independently, following discharge from hospital.

People told us that care staff were punctual and stayed the allocated length of time. One person told us that care staff would "sit down and have a chat" when they had time remaining before they left. However, one person said that staff "don't always arrive on time" but confirmed that they did stay the duration of the scheduled visit. The director told us that there was a system in place which monitored members of staff's punctuality and the duration of the call visit. They also advised us that people were told, and accepting, that call visits may be sometimes delayed due to unforeseen events, such as traffic issues. The coordinator told us that, in the event of any staff member being unusually late, they would communicate this to the person who was waiting for the member of care staff to arrive. Members of care staff said that they had enough travelling time between calls so that they were able to meet people's needs in a timely way and in line with their planned care.

Before the person's care started their needs were assessed to ensure that these would be met. The provider told us in their PIR how this assessment process was carried out, which stated, "We have supervisors who complete face to face assessments. Once this has been completed the supervisor then discusses the call times, duration and support package requirements with the cocoordinator (sic), who then looks to offer target times in line with their needs and wishes… Once all the above has been completed a start date would be put into place, this would be in line with the customer's [person's] request as long as it is safe to do so." The supervisor told us about how they carried out assessments of people's needs and that people were included in this initial assessment process. People confirmed that they were included in the assessment process. One person said, "[Name of assessor] came from the [agency's] office. They assessed me and I found they [the provider] was exactly what I needed."

There was an on-going review process to ensure that people's planned care continued to meet their needs. The supervisor told us that a review was carried out within the first week of the person's care starting. They said, "I do a telephone call to see how they [the person] is getting on and if they are happy with the care plan and the care." They also told us about subsequent monthly and six-monthly reviews. They gave an example of how one person's planned care was adjusted following such a review and this had helped the person with improving their hydration and nutritional health.

The registered manager and director told us that people's requests for a change in the times from their initial scheduled visits were taken into account during planned reviews. The aim of which was to improve

upon people's individualised care plans. One person told us that arrangements were in place for an up-coming review of their planned care. They told us that this would provide them with the opportunity to request additional help with their personal care and a change in the times of their care schedule. Another person told us that they had had a review of their planned care. They said that the review included them self, a member of the care agency and an employee from the local funding authority. The person said that the review had shown that the care was meeting their needs.

People were protected from unsafe care due to the availability of up-to-date paper and electronic records. Staff told us that information about people's care was easy to follow and kept up-to-date so that they had the up-to-date guidance to meet people's assessed needs. The director explained how the introduction of electronic records enabled staff to respond to people's needs. They said, "[The] major advantage is a system in improving the quality of people's care and the reduction of medicines errors. Office-based staff are able to monitor the care being provided…" One person said that members of care staff "go into my kitchen to write in the file before they leave." One relative said, "They [care staff] have the records on their 'phone and they always do that [make records of their visits] on their 'phone." This was to ensure that people received a continuity of care in meeting their assessed needs by means of maintenance of care records.

One member of care staff said that the information, other than that regarding people's medicines, was identical in both recording methods used. They explained that due to changes in people's prescribed medicines this was recorded elsewhere. Information about any changes, in relation to people's medicines, would be passed from office staff to care staff members. One member of care staff said that there was good communication between office- based staff and care staff.

We checked and found that the provider operated a satisfactory complaints procedure. People told us that they knew who to speak with if they wanted to raise a concern or complaint. One person said that they would speak with the care staff. They confirmed that they had access to information in relation to the provider's complaints procedure as they said, "It's on the front of my folder." One relative said that, if they were unhappy about their family member's care, they would, "Ring up the [agency's] office." However, they told us that they had no need to as they were satisfied with how their family member was being looked after. Written compliments told us that people had no reservations in contacting office-based staff. One of these read that the office-based staff were "helpful". One member of care staff told us how they would help people with the provider's complaints process. They said, "I would advise them [people] to use the [agency's office] 'phone number. Or I could get in touch with someone in the [agency's] office, if the person was not able to. Or I would raise the complaint myself." One person said that their complaint was raised by a relative on their behalf. They told us they were satisfied with the actions taken by the provider to improve the level of written communication in relation to a private matter.

The provider told us that in the previous 12 months they had received, and resolved to the person's satisfaction, three complaints. The complaints log demonstrated that the provider used the complaints procedure to improve the safety and quality of people's care. This included, for example, a change in staffing arrangements and arrangements made for staff to attend refresher training.

Good

Is the service well-led?

Our findings

We checked and found that the agency was being managed for the benefit of people and staff. The registered manager was supported by senior members of staff, who were responsible in supervising care staff, and a team of office-based staff. The registered manager wrote in the PIR, "The care manager supports me to ensure that all daily tasks are completed correctly and ensures prioritising. The care manager is also involved with induction training, refresher training, probation meetings, appraisals and supervisions within the field team. The care manager also ensures that the team are supported on a daily basis and that the correct policies and procedures are being followed ensuring best practice at all times."

The registered manager was aware of their responsibility in ensuring people received safe care by a team of well-managed staff. In the provider's PIR the registered manager wrote, "I support the management team to deliver the induction training to ensure that all team members have a good understanding of what it is I expect from them in the field."

We received positive comments about the leadership style of the registered manager, who staff described as being "approachable" and "supportive." One member of care staff said, "Anything I need I can ring up or go into the [agency's] office and speak to [name of registered manager.]" Another member of care staff told us, "If I go into the [agency's] office [name of registered manager] will speak to you and ask you how you are."

The provider valued staff and operated a 'Carer of the Month' scheme: quotes from the winners included, "It's good to feel appreciated and it's great to be part of the team." Another winning staff member was quoted as saying, "I feel very privileged and happy knowing my hard work and effort has been recognised." The director said, "There's been a development of staff and investing in our teams. With that comes good customer service."

People's views about their care was obtained during reviews of their care. The provider told us in their PIR that, "Where appropriate we also speak with family members/friends and other health professionals to gain feedback and any potential recommendations." People told us that they had been included in the reviews of their planned care.

Another method the provider had to gain people's views about their experience of the agency was by mean of surveys. During November 2016 surveys were sent out to people who, or their relatives, had completed. Those returned showed that people had very positive comments to make about the quality of their care. The registered manager described some of the remedial actions that they had taken in response to less than positive comments. This included, for example, changing the scheduled times of one person's morning call to be later and making arrangements for staff to attend training in Parkinson's disease.

'Spot checks' were part of the provider's quality assurance system during which members of care staff were observed at work. One member of care staff said, "Often they [spot checks] are unannounced. They [observer] make sure I arrive on time. That I wear gloves and aprons. [Watch me do] medicines." Another member of care staff told us that the 'spot checks' carried out on them were unannounced. They said, "I was

just met at the door [by the observer]." They confirmed that people were asked for their views about how they were being looked after, during such 'spot checks'. Members of care staff said that they had feedback following the 'spot checks'. One member of care staff said, "I was told I was doing okay."

In their PIR the provider gave examples of how they intended to improve the quality of people's care and the quality of their lives. One of these examples read, "We are looking to implement a wellbeing task that focuses on customers [people who use the agency] with certain behavioural patterns, for example, a customer who suffers with dementia. The idea of this wellbeing task is that we can monitor different patterns at different times of the day to gage (sic) when the customer finds certain visits or tasks within the visit difficult and implement approaches and strategy's (sic) that comfort the customer and make their visit enjoyable rather than stressful." Another example was an aim to reduce social isolation of people living at home by the introduction of a befriending service. In the provider's PIR we read, "….loneliness is a large issue within our community and this programme is designed to reach those who do not have family/friends to visit them and who are potentially alone with no one to talk to for days, weeks or even months. Bluebird Care Buddies is designed to work towards ensuring that loneliness becomes a thing of the past." These examples demonstrated that the provider had a system in place which continued to review and improve the quality of people's lives.

There were opportunities for staff to develop their career. In their PIR the provider told us how this was done and wrote, "Last year we implemented team leaders, this has worked well however due to the growth of the business it has become apparent that further roles were needed to ensure the service remains at a high standard. The new roles have now been identified and are currently being implemented." The co-ordinator told us that they were supported to attend further training and development in business management.

The provider operated an open culture by enabling staff to make suggestions and these were acted on. An example of this was described in the provider's PIR which read, "We send out surveys to our care team annually. One of the questions asks the team if there is anything else we can do to support them on a daily basis. The overall feedback was that the team would like their own area within the office to have a break or sit and complete paperwork without having to necessarily needing to speak with anyone. We have listened to this and have implemented Team Zones which are solely for the care team." During our visit to the agency's office we saw that staff had access to a dedicated place for staff to use as they chose to. One member of care staff told us that they requested more training, especially that for dementia care and management of diabetes. They said that the provider had acted on this request and arrangements were made for more training in dementia and diabetes which was to take place during 2017.

Another example of how the provider included staff in the running of the agency was via team meetings. Members of care staff said that they had attended these. Although they were unable to provide examples, they told us that they were able to make suggestions to improve the quality of people's care. In addition to this, the staff meetings gave the provider the opportunity to up-date staff in changes in legislation and policies and procedures. One member of care staff described the staff meetings as "informative". Another member of care staff said that the staff meetings helped team members to support each other. Minutes of the meetings were made available for all staff, even for those who had been invited but were unable to attend. Minutes of staff meetings demonstrated that staff were enabled to make suggestions. In addition the staff meetings provided the registered manager to remind staff about the expectations of their roles and responsibilities to keep people safe. This included, for example, reminding staff to maintain accurate records and follow correct infection prevention procedures.

Another example of how the provider was able to demonstrate an open and transparent culture was by means of having a whistle blowing policy and procedures in place. Members of care staff were aware of the

policy and procedures in protecting people from the risk of harm. One member of care staff said, "If I find something another carer is doing wrongly, I would go and tell the [registered] manager. Which I have done." They told us that they had reported such concerns and that the provider had treated them "fairly" and had listened to their concerns. They added that their identity was "definitely" protected from being disclosed to anyone else.