Adjuvo Primus Limited

# Bluebird Care Durham North

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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

This inspection took place on 12 and 18 October 2017 and was announced. This was to ensure someone would be available to speak with us and show us records.

Bluebird Care Durham North is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. Not everyone using Bluebird Care Durham North receives regulated activity. CQC only inspects the service being received by people provided with personal care; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. On the day of our inspection there were 13 people using the service, nine of whom were receiving personal care.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like 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 registered manager had been in post since the location was registered with CQC in October 2016.

This was the first rated inspection of Bluebird Care Durham North.

The service had a robust recruitment procedure in place and appropriate checks were carried out before they employed staff. Staffing levels were appropriate and any absences were covered by the provider's permanent staff. The provider used an electronic roster system that took into account people's preferences with regard to the care staff allocated to support them.

People who used the service received effective care and support from well trained and well supported staff. New staff completed a thorough induction, training was up to date and staff received regular supervision sessions.

Risk assessments were in place for people who used the service and staff and these described potential risks and the safeguards in place. The provider and staff understood safeguarding procedures and in practice they followed them.

Appropriate arrangements were in place for the safe administration of medicines.

People were supported with their dietary needs, and to maintain a healthy, balanced diet. People who used the service had access to healthcare services and were supported with their health care needs.

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

People who used the service and family members were extremely complimentary about the standard of care provided by Bluebird Care Durham North. Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible.

People were supported with their religious and cultural needs and the provider had an equality impact assessment in place to ensure they had identified any gaps in how they were able to support people from minority groups.

The provider had an end of life policy to ensure people's dignity and human rights were respected wherever possible at this important time.

The service was focused on providing person-centred care. Person-centred is about ensuring the person is at the centre of any care or support plans and their individual wishes, needs and choices are taken into account.

The service was very responsive to people's changing needs and the needs of family members who were their relative's carers. People's care and support was planned proactively in partnership with them and their family members.

The provider used a tool to evaluate and plan the current and future needs of people using the service. The tool allowed the service to make a clear plan of the person's future care.

The service had developed innovative ways of protecting people from social isolation and supported people with meaningful engagement and conversations.

No formal complaints had been recorded at the service. The provider and registered manager believed a contributory factor to this was their visibility and regular visits to the people they supported.

The service had good links with the local community and organisations. The provider was an active member of local groups, panels and organisations that had been established to support vulnerable members of the community and raise the quality of care.

The service had a positive culture that was person-centred, open and inclusive. The management team demonstrated and showed evidence of an 'open door policy'. Staff felt supported by the registered manager and provider, and were comfortable raising any concerns. Very positive feedback regarding the management of the service was received from people and family members.

The service regularly used reflective practice and peer review in order to continuously learn as both an organisation and a team. The provider gathered information about the quality of their service from a variety of sources and acted to address shortfalls where they were identified.

## 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 numbers of staff on duty in order to meet the needs of people who used the service and the provider had an effective recruitment and selection procedure in place.

The registered manager was aware of their responsibilities with regards to safeguarding and staff had been trained in how to protect vulnerable adults.

People were protected against the risks associated with the unsafe use and management of medicines.

### Is the service effective?

Good

The service was effective.

Staff were suitably trained and received regular supervisions.

People were supported by staff in making healthy choices regarding their diet. People had access to healthcare services and received ongoing healthcare support.

The provider was working within the principles of the Mental Capacity Act 2005 (MCA).

### Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect and independence was promoted.

People had been involved in writing their care plans and their wishes were taken into consideration.

People and their families were provided with support for end of life needs.

### Is the service responsive?

Good

The service was responsive.

People's needs were assessed before they started using the service and care plans were written in a person centred way.

The service was flexible and responsive to people's individual needs and preferences.

The service had developed creative ways of protecting people from social isolation.

## Is the service well-led?

Good

The service was well-led.

The provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

People, family members and staff were able to voice their opinions on the quality of the service.

The service had good links with the local community and other organisations.

# Bluebird Care Durham North

**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 12 and 18 October 2017 and was announced. This was to ensure someone would be available to speak with us and show us records. One adult social care inspector carried out this inspection.

Before we visited the service we checked the information we held about this location and the service provider, for example, inspection history, statutory notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We also contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff.

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 used this information to inform our inspection.

During our inspection we spoke with one person who used the service and seven family members. We also spoke with the registered manager, provider and two care staff.

We looked at the care records of three people who used the service. We also looked at the personnel files for three members of staff and records relating to the management of the service, such as quality audits, policies and procedures.

Good

# Is the service safe?

## Our findings

People who used the service felt safe with staff at Bluebird Care Durham North. One person told us, "Oh yes, extremely safe." Family members told us, "Yes they are wonderful. He does feel certainly safe, cannot fault them", "Oh yes [name] is comfortable and safe. They would certainly tell us if there were any issues", "Yes I can say absolutely [safe]" and "Totally safe and comfortable with the care workers."

The service had a robust recruitment procedure, which included a 'Value based recruitment tool' to help the provider identify potential staff who displayed the values they were striving to embed within the service. The registered manager and provider explained that recruitment was ongoing and additional staff would be recruited before they took on any more care packages.

We looked at staff recruitment records and saw that appropriate checks had been undertaken before staff began working for the service. Disclosure and Barring Service (DBS) checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults. Proof of identity was obtained from each member of staff, including copies of passports, driving licences and birth certificates. We also saw copies of application forms and these were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained. This meant the provider had an effective recruitment and selection procedure in place and carried out relevant vetting checks when they employed staff, and on an ongoing basis as necessary.

The National Institute for Health and Care Excellence (NICE) guidance, 'Home care: delivering personal care and practical support to older people living in their own homes (September 2015)' states providers should, "Ensure service contracts allow home care workers enough time to provide a good quality service, including having enough time to talk to the person and their carer, and to have sufficient travel time between appointments." We found the provider acted in line with this guidance.

A roster was provided to people so they knew who would be visiting them each week. Each person had a 'key carer' who was responsible for ensuring their needs were met. Family members told us their relatives received care from regular staff who worked in small teams. They told us, "Yes there is a team of three care workers", "There is a small team that comes. [Name] knows them all", "We have a team of two to three care workers. If anyone new is to start, the manager always introduces them to [name] so they can build a relationship up. We also get rotas so we know who is coming" and "Bluebird is not very big so we have a small but friendly team."

The provider used an electronic roster system that took into account people's preferences with regard to the care staff. For example, if people's preferred staff member was on duty, they would carry out the visit. Staff sent a text message to the office when they arrived and left the person's home and the roster was updated to show the call had been carried out. Lone worker risk assessments were in place for all staff. Staff told us,

[Registered manager and provider] are very good. We have to text when we arrive and when we leave" and "They always let us know who to contact if we need them and they always answer."

A person who used the service told us, "Yes they [staff] do turn up on time." Family members told us, "Very prompt, this is such a great feature of this company", "They turn up on time, unless it is an emergency. They stay, in fact they stay longer. They are just brilliant" and "They do not rush off. They come on time all the time." Staff told us they covered any absences amongst themselves and people never had missed calls. This meant there were enough staff with the right experience and knowledge to meet the needs of the people who used the service.

The provider had a risk and issue register, which was designed to ensure that any incidents, risks or near misses were recorded and acted upon immediately. This included an analysis tool and was reviewed weekly. We saw accidents and incidents were appropriately recorded, analysis was carried out to identify any causes or contributory factors and corrective actions took place. For example, a medicines error that had not resulted in any harm to the person was shared with the family of the person and shared with the staff team to reduce the risk of a recurrence.

Risk assessments were in place for people who used the service and staff and these described potential risks and the safeguards in place. An environmental risk assessment was carried out for each person's home that staff visited. This was to ensure staff were aware of any potential hazards in the home and had important information on the location of utilities in case of emergency.

The provider had a business continuity plan in place to cover any emergency situations so that people would continue to receive safe and effective care. A 'Safer home strategy' was in place and the provider referred the people they supported to the local safer homes initiative so people could receive support and advice from the police and fire and rescue service.

We saw a copy of the provider's safeguarding adults' policy, which provided guidance on recognising, recording and responding to any allegations of abuse, and the responsibilities of management and staff. There had not been any safeguarding related incidents, however, the registered manager understood their responsibility with regard to safeguarding. Staff we spoke with had a good understanding of safeguarding and had received training in the protection of vulnerable adults. We found the provider understood safeguarding procedures and had followed them.

We looked at a copy of the provider's medication policy and procedure, and saw people had medication support plans in place. These described the level of support people required with the administration of medicines. For example, one person managed their own medicines and did not require any support from staff in this area. Another person was supported with their medicines by their family.

Staff had been trained in the safe handling of medicines and received regular competency checks whilst administering medicines in people's homes. As a result of a medication error, the provider had redesigned their medication administration chart (MAR) so that any changes to routine could be easily identified and a visual prompt had been added to help identify all medicines. This meant appropriate arrangements were in place for the safe administration of medicines.

Good

# Is the service effective?

## Our findings

People who used the service received effective care and support from well trained and well supported staff. Family members told us, "Oh thoroughly trained, very professional in what they do. They dress appropriately, always wash their hands and appropriate clothing is worn", "They are certainly trained. They spend the time before to find out the needs. They then match the care workers with that experience", "We were concerned. Would young care workers be able to cope with [name]'s dementia but we were wrong. They are brilliant" and "They are very big on training. The management lead by example. The management really value training which you can see in the care workers."

Staff mandatory training included safe handling of medicines, moving and handling, safeguarding, first aid, mental capacity, and dementia awareness. Mandatory training is training that the provider deems necessary to support people safely. The provider's policies and procedures, and other relevant guidance, were stored electronically and staff could access them remotely. For example, if guidance was required whilst on a call visit.

New staff completed a thorough induction, which included the modules of the Care Certificate. The Care Certificate is a standardised approach to training and forms a set of minimum standards for new staff working in health and social care. As part of their induction, the provider told us new staff were introduced to people who used the service by the registered manager and carried out a period of shadowing the registered manager and care staff. Staff told us, "Basically [registered manager and provider] have taught me everything I know", "The training and support is amazing", "They gave me sufficient training at the start", "Refresher training is always available" and "If I need additional training, I get sent on it."

Staff received regular supervisions. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. Staff told us they received regular supervisions and observations whilst carrying out care in people's homes. None of the staff had received an annual appraisal as the service was less than one year old at the time of our inspection visit.

People had nutrition and hydration support plans in place. This included information on any allergies, food likes and dislikes, preferences for cooking and serving food, and whether the person had any specific dietary needs. One person managed their own shopping online but required staff to put the shopping away and serve food to them as they were unable to manage it independently. People who required support to maintain a healthy, balanced diet had menus devised to support them. Food was specifically chosen to be appealing, nutritious and easy to prepare during staff visits. Shopping lists were also prepared for people who required them.

Where people required support in making food and nutritional choices, the service used specially adapted menus, which included photographs of the meal to help them make choices. A person who used the service told us, "They make me wonderful breakfast; bacon, eggs, mushrooms. They make nice food for me." Family members told us, "They prepare what [name] likes. Food in the morning is prepared for lunch, put away in the fridge ready for [name]" and "They really look after [name]. They have gone through her diet

requirements. They have filled her fridge with fruit and veg."

Care records described the support people required with their communication. This included guidance for staff regarding people's preferred method of communication, their body language and whether they had any difficulties with eyesight or hearing. For example, one person's support plan stated, "[Name] is very expressive and will let you know through her facial expressions if she is happy or not."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA. The registered manager had a good understanding of their legal responsibilities with regard to the MCA and staff had received appropriate training. Staff told us, "[Registered manager and provider] keep us aware of mental capacity. We make sure we don't force people. It's all about consent and all about the client." Care records showed how people were supported to make their own decisions with regard to their care and support.

People who used the service had access to healthcare services and were supported with their health care needs. Staff members told us they took people to appointments and care records contained evidence of visits to and from external specialists including GPs, physiotherapists, speech and language therapists, occupational therapists, and consultants.

Good

# Is the service caring?

## Our findings

Family members told us staff were caring and respected the people they supported. They told us, "They do not make my relative feel embarrassed. They talk to him whilst they are doing things. They even make a joke of it so they can get the task done", "They are like a dream for us. They treat [name] with respect. They ask his opinion and when my relative is awkward they work around him. They are like a family", "Absolutely wonderful, cannot fault them at all. Kind, caring and respectful towards [name]" and "Delightful care workers. Respectful, professional, always dressed appropriately, kind and really friendly, warm workers."

People were supported with their religious and cultural needs where required. The provider had an equality impact assessment in place to ensure they had identified any gaps in how they were able to support people from minority groups or had any specific cultural requirements. For example, if a person did not speak English as their first language, this would be recorded in their support plan. Another action in progress was to collate a list of religious feasts and festivals to be made available to staff to avoid arranging visits on these dates.

The provider's statement of purpose described how the core values of the service were based on the 6Cs: compassion, care, communication, courage, commitment and competence. We saw a copy of the presentation provided to staff regarding the 6Cs, which described what compassion in practice meant to staff and how it could be practiced. Staff told us how they showed compassion in their work and demonstrated an understanding of respect and dignity. For example, "If we've helped someone to the toilet, we leave. They don't want us hovering around", "We knock on the door and shout if we can't see them" and "It's my nature to be respectful."

We saw examples of how staff had gone the 'extra mile' when supporting people. For example, one staff member telephoned a person to see how they were as they had noticed they hadn't looked very well the day before. When they got no answer on the telephone, the staff member called at the person's house and found the person on the floor. They immediately contacted the emergency services. Another example was when a person the service supported called the office as they were confused about what day it was and said they had no bread or milk. The provider told them not to worry, went to the shop and called at the person's house with bread and milk. These examples demonstrated a very caring nature from the provider and staff.

We saw records of text messages between the provider and family members where the provider had offered additional support. This included accommodating short notice changes to visit times or arranged additional visits based on the person's need, and offered to prepare a meal for the person and their family member for the evening. This was above and beyond the person's plan of care.

The provider had an end of life policy to ensure people's dignity and human rights were respected wherever possible at the end of their life. We discussed with the registered manager and provider how they supported people with their end of life care needs. They provided an example of how they had supported the family members of one person by making the funeral arrangements as it had been distressing for the family. They also told us how they supported another person with end of life care needs and had developed a care plan

around the person's wishes and requests. We saw all staff had recently been trained in communicating with people and family members about end of life. This showed the provider had invested in their staff so that they were able to provide people and their families with the support they needed at this important time

Care records described how staff were to respect people's privacy and dignity. For example it was important to one person that they were clean and smelled nice. They asked staff to make sure they were offered talc and sprays. Another person's support plan stated, "Ensure that I am given dignity and respect, and confidentiality is upheld at all times. The provider's 'Gender related care' policy described how people's needs should be met in line with their individual preferences. For example, their preferences with regard to the gender of the care staff looking after them. We saw from the rosters that people's preferences were taken into account.

People's independence was promoted where possible and care records described what people could do for themselves and what they needed staff to support them with. For example, "I am very independent and manage most areas of my life including the care that I receive", "I will turn myself independently on to the side of the bed", "With support I am able to wash, dress and use the toilet" and "I would like you to support me to get dressed and washed each day, promoting my independence throughout." This demonstrated the service aimed to support people to be independent and people were encouraged to care for themselves where possible.

The provider had an advocacy policy. Advocacy services help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities. The registered manager told us none of the people using the service at the time of the inspection had independent advocates, however, people were directed to a local advocacy service if required.

Good

# Is the service responsive?

## Our findings

The service was responsive to people's changing needs and the needs of family members who were their relative's carer. For example, we saw copies of communication between people and family members with the provider, showing that when people or family members had made choices about the times of visits or requested changes to visits, the provider had accommodated them. For example, a family member asked for two additional evening visits at short notice for personal reasons and the provider assured them a member of staff would visit on both evenings.

People's needs were assessed before they started using the service and continually evaluated in order to develop care plans. People's care records were person centred, which means the person was at the centre of any care or support plans and their individual wishes, needs and choices were taken into account. For example, a 'This is me' document was used to record information that was important to the person such as their preferred name, life history, important routines, things that may worry or upset them, how they communicate and their care requirements. A staff member told us, "It's all so person centred."

The provider used an 'Outcome star' tool to evaluate and plan the current and future needs of people using the service, and also those family members who were carers to people. The tool allowed the service to make a clear plan in terms of the domains included in the tool. These included staying as well as you can, keeping in touch, feeling positive, being treated with dignity, looking after yourself, feeling safe and managing money.

Family members told us they were involved in their relatives' care planning. They told us, "We discussed the care plan, the occupational therapists are involved. Management ensures all professionals are involved, it is so patient centred", "They always come and discuss [name]'s care, it is like he is the centre of the conversation. They listen to us. We work like a team to really identify his needs" and "We look and tweak the care plan together all the time." We saw a recent letter a person who used the service had sent to the provider. In it they stated, "I have always received the highest standard of personalised care" and "You are not only helping me recover but helping me transform my life by supporting me in tasks I have wanted to do but not been able to for some years."

Care records had been written in consultation with the person who used the service and their family members, and contained evidence of choice and decisions being made by the person. For example, how the person wished to be addressed, the person's preferred method of contact and how the person wanted their care and support to be delivered. Examples included, "I like to have my throws placed on my knee and one around my neck. It is important that I am warm as I feel the cold" and "I use the toilet during the day and need all floor areas to be clean, dry and safe so that I can move around easily and safely." Care records we looked at were reviewed a minimum of every six months and regularly evaluated.

Support plans described people's specific needs. For example, one person required support to mobilise, was unable to manage their own personal care and was at risk of skin breakdown. Their support plan clearly described their needs and what staff were to do at each visit. For example, support the person with their

mobility, assist the person with their repositioning to reduce the risk of skin breakdown, check skin integrity and apply barrier cream to affected areas at each visit. Potential risks had been identified and control measures were in place to reduce the risks. Any issues were to be reported to the district nursing team.

Daily notes were maintained by staff that included the date and time of the visit, details of tasks carried out, what the person was doing on arrival, activities carried out, and any choices the person made on the day. These records were audited monthly by the registered manager. Communication diaries were also in each person's home that allowed staff and family members to communicate by leaving notes for each other. For example, reminders of appointments and any additional requests.

The provider had a 'Collaborative working strategy' in place that was implemented to "reduce social isolation and loneliness." This was based on a Director of Public Health report regarding isolation and loneliness in County Durham. This was used to help identify people who may be at risk of social isolation and develop support plans for their social wellbeing. As part of the assessment process every person had a 'Circle of support' plan completed. The purpose of the circle of support plan was to help the provider identify who was in the person's life, what support and value they could offer to the individual, identify other areas of need that may have been overlooked and help identify people at risk of social isolation. This meant the service could provide holistic support to ensure people were able to fully access other services where needed and necessary.

People were supported with their social wellbeing. For example, one person enjoyed going out with their family and talking with staff about their family, pets and their past. Another person was identified as being at risk of isolation due to advanced dementia. The person enjoyed their visits from staff, where dementia themed activities, such as the use of a dementia doll, were being carried out.

The service had developed an initiative by supporting people and families to develop memory boxes to support meaningful conversations during care visits and reduce anxieties in those that experience difficulties in receiving personal care. Through this initiative, the service worked with Beamish museum who provided them with 'loan boxes' for people and family members who were unable to create their own. These were filled with old fashioned items that supported reminiscence therapy, meaningful engagement and conversations.

The provider invited all the people who used the service to their office for a coffee morning but due to the nature of care and support people received, some people were unable to attend. As a result, the provider decided to provide a mobile coffee morning which meant they took the event to people at their homes. This had been very well received by people and their family members.

The provider's 'Compliments, concerns and complaints' policy described the procedure for people to follow when raising a concern or making a complaint, and the timescales they could expect to receive a response. No formal complaints had been recorded at the service, and people and family members we spoke with did not raise any concerns. The provider and registered manager believed a contributory factor to this was their visibility and regular visits to the people they supported so any issues could be immediately resolved before they became a complaint.

There had been a number of recent compliments received by the service. These included, "She certainly came to appreciate your visits and the attention you provided was sensitive to her needs and above and beyond basic care", "It was personal care in the true sense of the word" and "I think you should be very proud of the standard of service Bluebird delivers."

Good

# Is the service well-led?

## Our findings

At the time of our inspection visit, the service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. We spoke with the registered manager and provider about what was good about their service and any improvements they intended to make in the next 12 months. The provider told us the focus of the service was on "high quality" and they made sure they had the capacity before taking on any new clients.

The service had good links with the local community and organisations. The registered manager and provider told us they had recently agreed a contract with three local GP practices to advertise their service. Leaflet drops had taken place in the local community and they further told us that the service is planning to run a jobs fair to promote the work they do. The provider was an active member of the local dementia action alliance group and the health and wellbeing advisory panel at Beamish Museum. The panel advised on how to support vulnerable members of the community and reduce social isolation through activities hosted by the museum, which we saw the service was involved in. The provider also attended meetings of the Tyne and Wear Care Alliance, which is an organisation that works collaboratively with professionals and employers in the care sector to raise the quality of care.

The provider was meeting the conditions of their registration and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Commission by law.

The service had a positive culture that was person centred, open and inclusive. The management team demonstrated and showed evidence of an 'open door policy'. All the people who used the service and their family members had the mobile phone numbers for the provider and registered manager and we saw telephone calls and text messages were responded to in a timely manner, even when contact was made out of hours. The provider and registered manager both participated in the delivery of care so they both experienced the service that was being provided to the people they supported.

A person who used the service told us, "The company is very nice indeed." Comments from family members included, "I can ring them at any time during the day, evening, weekend", "The management are excellent, very responsive", "I have to tell you I am delighted. I can compare this company with another company from which we received terrible service. Any problems, they get in touch. That is both [provider and registered manager]. They want to make the effort to build a relationship", "Management are brilliant, really accessible and keep me updated by phone or email", "Absolute trust in management. They keep me fully in the loop. They have given me such peace of mind" and "Management are brilliant, we have a great dialogue."

The service regularly used reflective practice and peer review in order to continuously learn as both an organisation and a team. For example, at team meetings one of the management team provided an example of something they could have done better. This encouraged the rest of the team to be open and transparent about their practice. Reflective practice was also a core element of staff supervision meetings.

Staff we spoke with felt supported by the registered manager and provider, and told us they were comfortable raising any concerns. They told us, "It's a lovely job, I love all the clients", "I love working with [registered manager and provider]", "Yes definitely. Anything we need, [registered manager] is on it", "It's a really good company to work for", "They encourage us to bond as a team. At team meetings we share information and best practice" and "[Provider] absolutely wants the best for the service."

Staff were regularly consulted and kept up to date with information about the service. Regular meetings took place and staff were sent a questionnaire to feedback on their role and what it was like working for the service. The registered manager and provider used a 'Virtual team huddle' to keep staff up to date with any relevant information. This was in the form of text messages and emails sent to staff on a regular basis and each update included a different code word that staff had to send back to show they had received and read the information.

We looked at what the provider did to check the quality of the service, and to seek people's views about it. The provider had a quality strategy, which was made up of four main components. These were the provider's model of care, which was based on the five CQC domains and helped to ensure that every aspect of need could be identified and acted upon; a key performance indicator dashboard that was used to monitor quality, safety, sustainability, staff team and customers; the risk and issue register mentioned in the Safe section; and a continuous improvement plan.

The continuous improvement plan (CIP) was used to drive quality improvement within the service and was reviewed on a weekly basis. The CIP included a number of key performance indicators (KPI) and a 'RAG' (red, amber, green) rating tool was used to monitor compliance. The provider had identified areas of best practice for each KPI and the actions required to address any non-compliance. For example, under the KPI 'Customer engagement and experience monitoring', the provider had plans in place to introduce a newsletter during December 2017.

The provider had established an internal 'Quality and safety group' to explore, scrutinise and gain a deeper understanding of quality within the organisation. This provided assurance to the management team that the service was providing customer safety, excellent customer experience and care effectiveness, and that strategic decisions were made with these in mind. The quality monitoring of records was carried out weekly by the management team. This included checking support plans and risk assessments were fully completed and up to date, equipment checks had been carried out, medication support plans were in place, visit sheets had been completed, reviews had been carried out, and all visits were scheduled and allocated.

Surveys had been sent to people to gauge the quality of the service and fed into the providers 'You said, we did' system, where any feedback obtained from staff, people who used the service and family members was reviewed and responded to. For example, a staff member had asked for better communication. In response, the provider had introduced the virtual team huddle. A person who used the service had asked whether staff would go with them to the hospital for an appointment. Staff had attended the appointment with the person and stayed with them while they were in hospital.

An online, independent review service was used to survey people about the quality of the service. We saw the service had received 99% positive feedback in July 2017 and 100% positive feedback in August 2017. A recent review posted on this website stated, "Mum had a bad fall recently and they sent a lovely card and box of chocolates for her. Lovely management team." Other recent comments include, "Frequently go beyond expectations", "The service provided is of the highest calibre" and "Always keen to support my needs and requirements." This demonstrated that the provider gathered information about the quality of their service from a variety of sources and acted to address shortfalls where they were identified.