TM Care Limited

Bluebird Care Windsor & Maidenhead

Inspection report

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Date of inspection visit:
09 August 2016

Date of publication:
05 October 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?	Outstanding ☆

Summary of findings

Overall summary

Bluebird Care Windsor & Maidenhead provides personal care, companionship and home help to people in their own homes. The office of the service is located in a business park in Maidenhead, Berkshire and covers the geographical areas of Windsor, Ascot, Bracknell, Maidenhead, Cookham, Eton and Datchet. This location is one of two that the provider is registered to operate. The service is part of the large franchise brand Bluebird Care, with multiple branches located across England. At the time of the inspection, the provider reported there were 35 people who used the service and 25 staff.

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

The address of the service changed in May 2014. At the prior address, the service was inspected twice under the Health and Social Care Act (Regulated Activities) Regulations 2010. At both prior inspections in 2013 and 2014, the service was compliant with the outcomes that we inspected. This is the first inspection and rating at the current address of the service under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received safe care from the service. The staff knew what abuse was, how to safeguard people in the event of suspected abuse and what organisations needed to be contacted. People had risk assessments, care plans and regular evaluation of their care to ensure their safety. Staffing deployment was satisfactory and calls were not cut short, missed and support workers fully utilised all available time at people's houses. People were assisted with medicines out of pre-packaged blister packs from the local pharmacy, or independently managed their own medicines.

The service was effective in the care it provided to people. All staff undertook an extensive induction programme and experienced staff attended necessary training to ensure they could provide the best personal care for people. All staff received regular supervisions with the registered manager and were able to set and achieve their own employment goals. Performance reviews were conducted annually with six monthly reviews. Recruitment and selection of any staff member was robust and ensured safety for people who used the service. Consent was always gained from people before care was commenced and people's right to refuse care was respected.

People told us staff at Bluebird Care Windsor & Maidenhead overwhelmingly caring, compassionate and committed to their roles. People we spoke with and feedback taken from our own survey and the provider's surveys demonstrated people rated the care good and would not hesitate to recommend the service to others. Staff often went beyond their role expectations to fulfil people's preferences, prevent social isolation and ensure people had the chance to pursue their hobbies or favourite interests. Staff knew people and their needs well. Care documentation we viewed was up-to-date and fully completed. The staff told us they

respected people's privacy and dignity, and ensured that life in their homes was as close as possible to being independent. People were able to say how they liked their care, and the service would accommodate their requests every time.

The service was responsive to people's needs. People and relatives had the ability to share their compliments, concerns and complaints in an open and transparent manner by communicating directly with the staff. People told us they would speak to office staff or the managers if they had a concern or complaint, but never had the requirement to do so. People also told us there was good communication from everyone who worked at the service, especially when something different needed to occur in exceptional circumstances.

People, relatives and staff we surveyed and spoke with felt the leadership of the service was outstanding. They told us they felt a personal connection with the service and the people who oversaw the functioning of the care provision. The service had a very strong connection and presence in the communities where care was delivered.

The service organised community events for people to attend in an effort to combat social isolation. The registered manager and nominated individual spoke at local meetings about age-related matters and received complimentary feedback about involvement. The service maintained further links in the adult social care sector by establishing working partnerships with relevant support organisations.

People and others had a regular opportunity to provide feedback about the service and have a voice in the model of care. Relatives and staff were also routinely surveyed and asked for their opinions about improvements the service could make.

Robust auditing of care and processes was undertaken by the registered manager in additional to independent auditing by an external quality manager. This ensured the service was transparent, accountable and willing to make changes when needed.

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.

People were protected against abuse or neglect.

People's risks for care were adequately assessed, mitigated or resolved.

People's care was safe because of good staff deployment.

People's medicines were safely administered and recorded.

Is the service effective?

Good

The service was effective.

People were cared for by well-trained and knowledgeable staff.

People's consent for care was obtained and the service was compliant with the provisions of the Mental Capacity Act 2005.

People were supported to maintain a healthy balanced diet.

People were supported to have access to healthcare services and receive ongoing support from community professionals.

Is the service caring?

Good

The service was caring.

People were treated with genuine kindness and compassion.

People had a say in the service and what they felt needed to improve.

People's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

People's care was personalised and documented appropriately.

Staff had good knowledge about people they cared for.

People's had the right to make complaints and knew how to.

Is the service well-led?

Outstanding ☆

The service was well-led.

Management ensured a positive workplace culture for staff.

There was a robust and detailed system of quality assurance to measure good care for people.

The service had clear objectives and worked through a plan to ensure positive outcomes for people.

The service embraced partnership with local organisations and showed support to the adult social care sector.

Bluebird Care Windsor & Maidenhead

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.

The inspection was undertaken by one adult social care inspector and took place on 9 August 2016 and was announced. The provider was given 48 hours' notice because the location provided personal care in the community and we needed to be sure that staff and managers would be present in the office.

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 also reviewed information we held about the service. This included previous inspection reports and any notifications we had received. A notification is information about important events which the service is required to send us by law.

Prior to the inspection, we sent a number of surveys to people who used the service, staff and relatives or friends of people. We received 12 survey responses back from people and their relatives. We received seven responses from staff. Prior to the inspection, we looked at the provider's own website, other adult social care review websites, and social media to gain further information about the service. During the inspection we spoke with the nominated individual, registered manager, the training manager, and five other staff including care workers.

After the inspection, we spoke with seven people who used the service in telephone interviews. We also spoke with one relative after the inspection. We did not visit people's homes as part of this inspection. We contacted local authorities for their feedback regarding the service.

We looked at four people's individual care records. These included support plans, risk assessments and daily monitoring records. We also looked at four staff personnel file and records associated with the management of the service, including quality audits. We asked the provider to send us further information following the completion of the office-based part of the inspection. We received the information and included this as evidence for our report.

Good

Is the service safe?

Our findings

In the survey responses we received prior to the inspection, all people who used the service, relatives and staff agreed that the care was safe. After the inspection, all of the people we held telephone interviews with told us they too felt safe with the care they received and with the support workers who visited them in their home. People told us that staff announced their arrival to their house when care was due, that the service's office usually called them if routine plans for visits changed, and that they established rapports with staff easily. People's comments included, "They seem to be very pleasant and they do what I ask them to do" and, "I've got to know them all; almost friends…" A relative also commented that their loved one felt comfortable with the care. They told us, "They are so lovely, a great help and we get on well. They are very patient and attentive."

Staff we spoke with knew what safeguarding meant and how to prevent, identify and report abuse. The service had a safeguarding policy dated 2016 which reflected what managers and staff needed to do if abuse or neglect was suspected or detected. When we asked what type of abuse could occur to people, staff told us that there were different types of abuse and potential signs or warnings that abuse may have occurred. There was also a whistleblower policy dated 2016 which provided staff with information about how they could report concerns if they felt uneasy about doing this with a manager. Staff knew what neglectful care was and told us that they would not want people who used their service to be neglected. People and staff felt the scheduled visit length enabled them to prevent neglect and that calls were not cut short or missed. The service had the contact details for the local authority safeguarding team. The service routinely trained staff in safeguarding at the commencement of their employment and then regularly afterwards. Safeguarding was a topic also discussed at staff team meetings, to increase awareness.

A number of assessments were completed before people commenced receipt of care from the service. This included a full pre-assessment where people's health, social situation and requested care and visits was discussed. We saw these included discussions between the service, the person who would use the service, relatives and sometimes hospital staff. The discussions focussed on obtaining information to ensure the service could meet people's needs in their homes safely. The number of visits received by the person was also agreed at the first meeting with the provider. Calls were planned for personal care for most people, and some people received help in the community or for companionship. Assessment tools documented risks for the person's care and how the risks could be reduced. For example, we saw completed environmental risk assessments, medicines safety assessments and falls or mobility risk assessments. We found the assessments for people's risks were suitable for the service and appropriately documented people's individual needs.
The service also considered other risks that might occur in the provision of care to all the people who used the service. We saw the service had drawn up a business continuity plan which was last reviewed in June 2016. This documented what to do if there were unplanned events, like severe weather or a group of staff not being available all at once. The plan recorded the actions the service would take in these situations and ensured people would be as safe as possible.

Recruitment of staff to the service was a robust process. It involved a number of steps or stages to ensure

that the fit and proper staff were selected to provide personal care. The registered manager told us they sorted applications based on applicant experience, skills and knowledge of the personal care process. Pre-interview screening of applicants was the first step for potential new staff. Applicants were also required to complete application forms and submit their CV. Office-based interviews occurred where scenario-based questions were used to test applicants' suitability for recruitment. Recruitment also involved English language and mathematical tests. This meant staff were ranked according to their ability to safely undertake the job. When we looked at four personnel files, we saw all necessary checks were completed by the service in line with the regulations and to ensure people were safe. This included recording proof of the staff member's identity, performing criminal history checks and obtaining references.

Satisfactory numbers of staff were deployed to provide care to people. Staffing was based only on people's needs. Where a person's needs were complex or time-consuming, more than one care worker was allocated to attend the person's calls. People's care needs ranged from one call per week to live-in carers. After commencement of personal care, a person's needs were reviewed to ensure what was initially planned with them matched their current situation. Staff had reasonable portfolios of people to provide care to. The service used a computer program which analysed staff travel between calls, sickness and any untoward circumstances. When this was found by office-based staff, ad hoc changes were made to people's calls. It was not always possible to contact people prior to changes, although in some situations the office staff would attempt communication with the people the changes affected. 'Rounds meetings' were held with staff to determine their patch for people's care and the planned travel routes. When staff left the service, planning for new staff recruitment, induction and training was commenced before the staff that were leaving had finished work. This ensured continuity for people and that they were always safe with care delivered by skilled and experienced staff. The service continually recruited care workers to keep up with demand, and had an agreed protocol if staffing levels could not safely meet all people's needs.

People were safely assisted with their medicines. The staff we spoke with told us this mainly involved them taking the medicines from pre-prepared blister packs, and helping the person to take the tablets with fluids. Staff explained that where people were able, they would administer medicines to themselves rather than the staff member taking over. The registered manager also explained that where it was possible, the service promoted people to be independent with taking their medicines. Staff were required to undertake mandatory medicines training in induction, refresher training, regular competency checks and 'spot checks' from senior staff. In the service's office, we looked at a sample of medicine administration records. We found these were correctly completed by staff and that there were no errors in the sample we viewed. In the Provider Information Return (PIR) the service disclosed 13 medicines incidents were reported in the 12 month period prior to the document's submission to us. We found the registered manager took these incidents seriously, checked why the incidents occurred and tried to prevent repeats of the same errors. The staff were honest when medicines incidents occurred and demonstrated they reported them.

Good

Is the service effective?

Our findings

We asked people whether the service was effective. In surveys before the inspection, people agreed they received care and support from familiar, consistent care and support workers. Six people we spoke with after the inspection told us that care workers sometimes arrived late. People had different experiences of whether the service contacted them when care workers were late to support visits. One person said, "If they are late it is normally to be with a previous call. They are not given enough time between calls." Another person told us, "If they are late they will explain the problem. I'm OK with that." All six people we spoke with told us that they had never missed a call from the care workers. We asked the provider to send information to us after the inspection regarding missed calls. We looked at evidence for the period of 1 April 2016 to 30 June 2016. We saw there were four missed calls for the entire period. This was a low number compared to the size of the service. This meant people's care visits were rarely missed.

The service ensured that all staff were knowledgeable and skilled about personal care. At times, office-based staff or the registered manager provided personal care to people in their homes, and therefore had to ensure their own knowledge and skills were kept up-to-date. We found staff completed a combination of training pertaining to adult social care and their roles. This included education from online, face-to-face training by attending courses including Diplomas in Health and Social Care. Some staff had already undertaken or completed formal qualifications to help them perform their roles effectively before they commenced employment with the service. For staff that did not already have a formal qualification in care, they were encouraged and supported by the provider to obtain one as part of their role. The provider sent evidence of the care workers' active requests to undertake further education and training. We saw evidence that support workers had also completed an appropriate induction programme. As part of the inspection, we observed the provider had refurbished a part of the office so there was a dedicated room for staff training, study and communication between staff.

Staff received regular comprehensive supervision sessions with their line managers. We found staff also participated in and completed annual goal-setting and performance assessments. Staff told us they felt comfortable approaching any of the managers regarding performance matters and that management took steps to assist them in every circumstance with their learning and development.

The provider had ensured that the learning for the support workers was in line with Skills for Care's 'Care Certificate'. The service had identified that some service users required complex care. For example, people in their homes required stoma care and care and help with artificial feeding. We saw the service had organised various experts in the community to deliver specialist training to staff. This meant people with different care needs could be accepted for home visits with the service.

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. We checked whether the service was working within the principles of the MCA.

The service was working in line the requirements set by the MCA. Consent was always gained for people's care. Where people who used the service had the capacity to consent for themselves, they had signed consent forms. The consent forms included the information necessary about how to make an informed decision. This included things like what the care would be like, what benefits there was to the care and their right to refuse if they felt the need to. Staff we spoke with stated they would respect people's right to refuse care, but at the time people were accepting personal and care without any refusals. The service had never applied to the Court of Protection for people who did not have the capacity to consent to care, but knew the process if they ever needed to. Appropriate forms, policies and procedures were in place pertaining to consent and best-interest decision making, in line with the MCA. We provided advice to the registered manager that they review the use of best-interest decision making for people who may not have capacity to consent to care. This was so the service remained in line with the consent principles in the MCA when a person could not consent and a power of attorney was not legally-appointed.

Some people who used the service received assistance with their nutrition and hydration. The staff completed tasks like shopping, cooking, assisting with eating and drinking, cleaning up after meals and storing food away. The registered manager told us the service respected people's choice for their meals and also ensured that people had a balanced diet. We looked at a sample of people's care plans for nutrition and found these were appropriate. Where concerns were raised about people's weights, referrals were made to community dietitian. All food and fluids consumed by people in the presence of staff was recorded and monitored. In the care files we looked at, we saw people's preferences and dislikes regarding food and fluids were recorded and by staff.

Some people were supported by the service to attend all necessary medical and healthcare treatment appointments away from their own homes. Examples of good support to people related to healthcare included staff assistance with GP and other health professional appointments. Staff had an awareness of people's medical conditions and how to help them maintain a healthy lifestyle. Staff were committed to ensuring that where possible, people who used the service were not disadvantaged in gaining this care based on their limited ability or mobility issues. The support workers also liaised with local authority care managers and district nursing services when they required the guidance or provision of nursing care for people who used the service.

Good

Is the service caring?

Our findings

In both our pre-inspection surveys and post-inspection telephone interviews, people expressed that staff who visited them were always caring. One person told us, "I am very pleased with them. They are nice girls." Another person stated, "They are very caring. The [care worker] looks after me like a mum." A third person who used the service said, "They are absolutely wonderful. Always have a cheery hello and smile." Recent reviews from care service rating websites were also positive. One review stated, "All the carers that come to see me are always nice to see and give me great care and support." Another person who posted comments about the service on the internet wrote, "They treat my husband with respect and are very kind to him and he gets on very well with all of them. The carers leave the bathroom and bedroom tidy when they leave. I am very pleased with them, they always have time to talk to me about any worries I have." This showed a wide range of people in the community felt that the service was caring.

People and relatives were openly and regularly encouraged to have their say in the service. Customer questionnaires were sent periodically and the results were collected and analysed. We looked at the October 2015 survey results. The service had sent 42 survey invitations and received 20 responses from people and relatives. We found the service took on board the feedback from the survey responses. People said they wanted to be better informed about changes of call times and changes in their regular care worker. The registered manager created an action plan which detailed steps they would take to improve their service in this area. For instance, we saw that additional meetings with care workers and that better methods of communication with people were introduced. This showed that the service was interested in providing a genuinely caring and compassionate approach to personal care. We found this was reflected also in the conversations and interviews we held with the nominated individual, registered manager, care workers and office-based staff.

In the care files, we found that people's opinions of the care were reflected in the documents used to record planned and delivered care. We found the staff consulted with people about their needs and recorded and respected their preferences. People were always involved in their care planning, reviews of care and we saw evidence of this in the four care files we viewed. We saw relatives were invited to participate in goal setting, with the consent of the person who used the service. Care plans were documented from the person's point of view, with clear information the person and relatives could understand. The care plans reflected goals the person wanted to set for themselves rather than the tasks that care workers were to perform. This was evidence of best practice in involving people in their care decision-making process.

We did not visit people in their homes as part of this inspection. However, we still found that people received personal care which was dignified and respectful. When we asked six people during telephone interviews whether their privacy and dignity was respected by staff during visits, they responded positively. Confidentiality in documentation was maintained and records were stored away securely. We found both paper-based and electronic based communications were secure and not available to others who were not authorised to access them. Paper based folders in people's homes contained only essential information, and historical records were taken back to the office base for filing or archiving. When we asked for records as part of the inspection process, the office was able to immediately locate the items we wanted to examine,

and that it was easy to find the information we sought. The provider was registered with the Information Commissioner's Office in line with the Data Protection Act 1998.

Good

Is the service responsive?

Our findings

We asked people how responsive Bluebird Care Windsor and Maidenhead was. From our pre-inspection survey, all people that responded stated their care was personalised to them. From our conversations with them after the inspection, there was also good evidence that the service was responsive to people's needs. Using our 'share your experience' form on our website, a relative had responded, "The quality of personal care, support, friendliness and kindness my mother receives is very good. We were particularly impressed with the way the carer and the agency dealt with my mother when she had a medical emergency recently, staying with her for over three hours until she was hospitalised and them not charging us for the extended time the carer remained with her. The quality of care, especially in an emergency like this, is very reassuring for her both of my mother's daughters who live 250 miles away in two different parts of the UK."

People who used the service had their personal needs and preferences taken into account before care commenced and throughout the provision of the package. People were free to choose what aspects of care they needed assistance with, and the service would allow people to remain as independent as possible. Consistency of staff was also an important factor for people who used the service. When we spoke with people, the majority of them told us they always had the same support worker or workers who visited. Where support workers were away on any kind of leave or circumstances prevented the usual staff member attending, the service called the person ahead of time to inform them of any changes. People also received their care schedules on a regular basis from the office. This prevented people expecting their routine support worker and prevent being surprised when another staff member came to provide their support or care.

We reviewed four people's care documentation to look for evidence of person-centred care. We found the care was planned, implemented and evaluated on an individual basis. One person's care plan stated they were anxious about eating. The documentation showed this was a risk for the person and that if they did not maintain their nutrition they could become malnourished. The plan showed clear objectives to prevent this occurring for the person. We saw it included involvement of the family as the person was dependant on their support. The plan showed that reassurance from the person's relatives and care workers may positively influence the amount of food they consumed at each visit and at other times. Care documentation also included a form titled 'what is important to me' which documented people's interests and key aspects of their life. This served as a ready tool for new care workers who were commencing to care for the person and get to know them quickly.

The seven people we spoke with after the inspection told us they never had a complaint about the service. All of the people we spoke with told us they knew how to make a complaint, and would have no hesitation speaking with either their care worker or the registered manager. Some people we spoke with told us they were telephoned by the office at one stage to ensure they were satisfied by the service and were asked if the service needed to be amended in any way. We also found the provider had a complaints system in place. No one had made any formal complaints to or about the service. The Care Quality Commission and local authority also had no records of concerns or complaints about the service.

When we spoke with support workers and the registered manager, they knew how to informally and formally respond to complaints. They told us they would gain as much detail about the allegation as they could and try to quickly implement a solution to ensure people, relatives and others were satisfied with the service. Where a complaint might be about the registered manager, people were free to raise their complaint with the local authority and other public bodies, where appropriate. Complainants could also go to the services nominated individual or the provider's head office. The registered manager told us that if a complaint occurred, after an investigation they would create and implement actions to prevent the complaint from recurring. The service also had the necessary policies, procedures and documents to record, assess and deal with any complaints.

Outstanding ☆

Is the service well-led?

Our findings

People and relatives told us they felt the service was well-led. From our pre-inspection surveys, eight people and three relatives knew who to contact at the service when they needed advice or assistance. Our survey also showed that people and relatives were asked for their opinion about the standard of care the service provided. This showed the service was mindful of people's opinions. When we spoke with people after our inspection, some told us that they had interacted directly with managers and they felt they were listened to. They told us the registered manager had offered their support, guidance and offered to change things when they were requested. People also told us that senior staff had visited them in their homes when a package of care was in consideration or when an audit of the care was undertaken. People we spoke with felt that the service had a management team who were transparent and accountable.

People's comments about the management of the service included, "We are quite satisfied", "The supervisor will ring and check everything is OK. New girl in the office is very efficient" and, "You have no trouble speaking to them." People were content with the care they received. One relative wrote to a senior staff member of the service to state, "Just a note to say thank you so much for all your help on [date] with my mum…after she passed away. Your help was invaluable and made her passing so much easier to cope with, knowing that I wasn't on my own. Thank you so much."

Staff we spoke with felt there was a positive environment at the service, and believed that the service was further enhancing the working conditions for them. One staff member commented, "I'm really happy to work for this care agency. They are always very supportive with me and with our customers. I would highly recommend this agency to anyone who needs a care assistant and also anyone who would like to work as a care assistant." This showed that staff were keen to participate to the provision of good care to people who used the service. We found the provider had worked towards development of an even better workplace culture for staff. In fact, this was the first goal set by the service for the 2016 calendar year. When we checked, the service goals for 2016 showed this.

Staff we spoke with had complimentary opinions of the management of the service. Care workers told us they felt the registered manager and nominated individual were approachable and empathetic. They told us they considered them more like 'family' than like a 'manager'. Staff told us the management were interested in the care of people, and that the delivery of care and support was their highest priority. Staff realised that the management team sometimes had time constraints because of busy roles, but told us their thoughts or concerns were always heard and acted on. Staff felt management were approachable and they did not have concerns in communication with them.

Regular consultation between staff and the service management occurred. We saw this included staff memos, newsletters and meetings. There was a myriad of other evidence to demonstrate the service was well-led. For example, we saw there were celebrations when care workers successfully achieved a diploma in health and social care. The provider, in conjunction with other locations within the brand, held their own version of an 'X Factor'-style contest. We saw evidence various staff were nominated and participated in the competition. Nominations were based on categories like best registered manager, 'dignity in care' and

putting people first. The location's staff finalists were then invited to attend a gala event in Brighton to determine who the overall winners of care were in 2015. This was an annual event and at the time of the inspection, new nominations of care workers who provided excellent care were progressing.

The management further encouraged staff growth and best performance of their caring roles for the benefit of people who used the service. A December 2015 staff newsletter we looked at showed that the service was keen to listen to staff and take action to implement initiatives that were fed back throughout the course of work. An example was that in 2016 the service implemented more dementia, bowel cancer and Parkinson's disease training. These are not always standard topics that care workers in the domiciliary care sector may necessarily obtain from a provider. Also staff were given the opportunity of guaranteed hours. This corroborated with intelligence information we had that the staff turnover rate of the service was much lower than the industry average. This meant staff did not start and resign as much, which improved continuity of care for people.

The Provider Information Return (PIR) sent to us prior to the inspection revealed some different initiatives the service used, which showed they had a passion to ensure excellence to people. These were ideas derived by the management team and from individual care workers. For example, for two years the service had partnered with a charity called Anita's Angels. Anita's Angels is a UK-wide initiative to help reduce isolation of the older adults in their own homes. As part of the partnership the service delivered wooden red roses to the people who used the service and offered them a complimentary one hour-long social call for companionship. This initiative proved a success with people and the service intended to continue and repeat the process each year.

The service also wanted to promote genuine kindness from staff to people they cared for. They had taken some further steps in an endeavour to instil this in staff. In the care worker lounge, we saw the service had created a 'focus wall' which showed an employee of the month, compliments received from people, photos of events staff and people were involved in together and motivational quotes.

We examined the employee of the month programme further to determine how this related to people who use the service. The scheme was implemented by the management team. Nominations for the scheme were anonymous and consisted of staff placing their vote in a box in the care worker lounge. The service then tallied votes for each month and named the employee of the month. The monthly winner was provided with the company car for the month and a £50 bonus in their pay. This was a way that recognised the dedication to care an individual care worker demonstrated. For example, we found staff that were recognised as the employee of the month were nominated when they had performed their role in an excellent way. This sometimes extended to a staff member doing something for a person that was not part of their care package, but to the benefit of the person's life. The service also donated £1 to a chosen charity each time there was a nomination for a care worker to be the employee of the month. People and relatives were also encouraged to nominate staff who they felt had gone the 'extra mile' for them by sending regular reminders and memos.

The service had a strong inclusion in the local community through a number of channels. We found the service wanted to integrate with the towns and villages they provided care to people in, and regularly became involved in, or completely organised, community events. Building links with the community was inherent to the model of service the provider desired to operate. There were a number of examples of the service engaging with people who used the service, their relatives and other members of the general public who did not directly use the service. An example was
Celebration of 'dementia awareness week'. In association with the Alzheimer's Society, a coffee morning was hosted with local businesses. At the event, the service promoted the understanding of dementia, raised

awareness of support organisations and listened to community members' experiences of dementia. Another example of partnering with the Alzheimer's Society was staff participation in the Maidenhead 'boundary walk'. The activity, planned for 2 October 2016, had staff registered to complete the 13 mile walk and raise money. The money raised would be donated in honour of a person who had used the service but was deceased. Other examples included the nominated individual and another director competing in a marathon and bike ride to raise money for other charities.

We found further evidence of community interaction occurred between the service, staff and support organisations. The service met with the Twyford branch of Age Concern in 2016. Age Concern's purpose is to visit people in their home to encourage socialisation and 'sign post' people to functions like how to create a lasting power of attorney. Staff were provided the information about the service's meeting with Age Concern so that they could share this with people they cared for, as needed. When we asked the nominated individual what the future intention of the service with this organisation was, they explained they wanted to promote further joint working to better enhance people's personal care. This activity showed the service actively partnered with other organisations.

The service had an operational model which placed people at the centre of care. This was reflected in the provider's Statement of Service (SoP). The provider last updated their SoP in 2016 and submitted this to us. The mission of the service was stated as: "…provide expert quality care to keep you safe and comfortable in your own home". When we inspected the service, we found evidence that the service's model was in practice, as people had received stated reviews, and there were comprehensive, holistic logs of communication specific to each person. Where people's care deviated away from the core principles of care set by the service, the registered manager and senior office staff checked what could be done to ensure the person's care had returned to the level of quality required. This demonstrated a strong leadership team who detected issues as they arose and acted swiftly to ensure compliance and satisfied people who used the service.

We found at the beginning of the year the service set out the plans for the business for the entire year. A copy of the 2016 plan was provided to us for review. Examples we saw on the plan showed introducing the 'PASS' system (an electronic care recording method) and classroom-based dementia training. Throughout the year, the service decided how and when to introduce the changes and who in the team was responsible for making it happen. We also viewed individual office-staff care goals for the year stemming from this service plan. The monthly meetings also enabled the management team to discuss team performance and any further support they could offer, and urgent decisions or actions that may be needed. This was a clear demonstration that the service was well-led.

The service used an intense, robust network of quality assurance techniques and tools to ensure best practice for people who used the service. Underlying the quality checks was the location's 'domiciliary care dashboard'. The 'dashboard' measured, in real time, the operation of the service. Examples of items measured were safe capacity of hours of care, continuity of people's care, care reviews and staff supervisions. Other factors the dashboard tracked were numbers of recruitment enquiries, numbers of pre-service assessments and numbers of new people starting care with the service. We saw information and results from the 'dashboard' used to inform management in good decision making. The management team then held monthly business development meetings that allowed them to review results and focus on making continual improvements to the way we people received their care.

We saw a keen focus displayed by the registered manager, office staff and the nominated individual on checking and improving care. The management team were involved in routine and extraordinary checks of the level of service for people who received care. We found examples included 'spot checks' of staff that

provided care to people in their home, routine auditing of staff record keeping, telephone interviews with people who received the care and complete periodic reviews of people's entire care package. Additionally, the service had an annual office audit completed by the externally-appointed quality manager from the brand provider. The quality manager used our standard set of key lines of enquiry (KLOEs) to audit the service. We looked at the most recent office audit for the service. Within pre-determined criteria, the service had scored a compliance rate of 92%. We could see the audit was honest in the approach. For example, the results showed that one staff member's training on a particular topic was overdue. This was then used to plan book the staff member's refresher training on the topic.

The service was keen not to make errors in any aspect of people's care, including processes supported from the office. We found a unique system that tried to ensure step-by-step processes were followed by staff to always ensure best outcomes. Some of the service's standard functions were documented on a system called 'sweet process'. An example we viewed was what to do in the event a care worker attempts to resign from their post. The outcome was to ensure that avenues for retaining the staff member in post were explored and documented. The methodology from 'sweet process' allowed any member of staff to follow an easy to read guide on dealing with situations not covered by particular policies. The service had commenced the introduction of videos, presentations and aide memoires for this. This meant, even in the absence of the registered manager or other senior workers, staff knew exactly how to perform particular tasks and ensure they were fully completed.

Providers are required to comply with the duty of candour statutory requirement. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to registered persons when they are carrying on a regulated activity. The registered manager and nominated individual were familiar with the requirements of the duty of candour to people and had a policy at the time of the inspection. Both staff we spoke with were able to clearly explain their legal obligations in the duty of candour process. The provider did not yet have an occasion where the duty of candour requirements needed to be utilised. We have asked the provider to ensure that duty of candour is a part of regular training for all staff across the service.