Primare Limited

Bluebird Care (Manchester South)

Inspection report

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20 October 2016
24 October 2016
26 October 2016
28 October 2016

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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

This inspection took place on 20 October 2016 and was announced. We gave the registered provider 48 hours' notice of the inspection because it is a community based service and we needed to be sure the office would be staffed and sufficient information would be provided to allow us to contact people in their homes. We contacted people who received a service on 24, 26 and 28 October 2016.

The service was last inspected on 17 September 2013 and was found to be meeting the regulations we inspected against.

Bluebird Care (Manchester South) is registered to provide personal care to people in the community, living in their own homes. At the time of the inspection there were 36 people receiving a regulated activity.

The service had 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.

People and their relatives told us they felt safe receiving support from care workers and were happy with the service.

Staff had a good understanding of safeguarding and had received up to date training. Staff were confident in their role to safeguard people and told us they felt confident to raise any concerns. All safeguarding concerns were reported to the local authority, were investigated and appropriate action was taken where necessary.

People had appropriate risk assessments in place where required which were clearly linked to associated care plans. The service also had general risk assessments in place covering environmental factors and work tasks.

Medicines were managed and administered in a safe way. MAR sheets were fully completed and staff received regular competency checks as well as appropriate training to enable them to administer medicines.

People and relatives told us there were enough staff to meet their needs and staff rotas reflected this. People received support from a consistent cohort of carers where possible. The care co-ordinator explained how they tried to ensure people were supported by the same staff members when possible. Staff were recruited in a safe way with appropriate checks carried out prior to them providing care and support to people.

Staff received regular training and all mandatory training was up to date. The service encouraged staff to

complete additional courses such as National Vocational Qualifications (NVQ's). One care worker told us they had recently discussed pursuing an NVQ training course with the registered manager during a recent supervision.

Staff told us and records confirmed they received regular supervisions. Staff also received annual appraisals which were recorded and included training and development opportunities as well as achievements and areas for improvement.

Staff understood the principles of the Mental Capacity Act 2005 (MCA) and were able to describe how they gained consent from people prior to providing support. Staff understood the importance of gaining consent from people, respecting their decisions if they chose to refuse an aspect of their care and the importance of encouraging people to make decisions.

People were supported by staff to meet their nutritional needs where appropriate. Specific care plans were in place containing adequate detail to inform and guide staff how to provide effective support to people. People told us staff members asked what they would like to eat and made whatever they wanted.

People and relatives spoke highly of care staff and felt they were friendly, kind and very nice. People felt comfortable and at ease receiving support from staff.

Care plans were personalised, detailed and updated regularly. People and their relatives felt involved in planning their care and were confident communicating any changes they wanted to management.

People knew how to make a complaint and felt confident to do so. They informed us they had no issues or problems with the service to complain about. The registered manager investigated all complaints received and took appropriate action.

The registered manager operated an open door policy and staff were happy that they could approach management with any issues or concerns and felt supported in their roles because of this.

Regular staff and senior team meetings took place as part of ongoing monitoring and improvement of the service.

The service regularly received compliments in the form of thank you cards, emails and letters from people who received a service and relatives.

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.

Staff had a good understanding of safeguarding people and were confident in their roles.

People had risk assessments in place where required.

Medicines were managed safely

Staff were recruited safely and there were enough staff to meet people's needs.

Is the service effective?

Good

The service was effective.

Staff had up to date training in all mandatory subjects as well as additional training. The registered provider encouraged staff to pursue further training and development where possible.

Staff felt supported in their roles and received regular supervisions as well as annual appraisals.

People were supported to access services from health professionals.

Is the service caring?

Good

The service was caring.

People and relatives told us the service was caring and staff were lovely and friendly.

Staff maintained people's dignity and treated them with respect. People's personal preferences were considered in their day to day routines.

People had access to advocacy services.

Is the service responsive?

Good

The service was responsive.

People told us staff supported them to meet their needs and they felt in control.

Care plans were detailed, up to date and personalised to each person's individual preferences.

People felt confident raising complaints but informed they didn't have any issues with the service.

Is the service well-led?

Good

The service was well-led.

People and relatives were satisfied with the service they received.

The registered manager operated an open door policy and staff felt comfortable approaching management with any issues or concerns.

Regular staff and senior management meetings took place to discuss and monitor service delivery for continual improvement and development.

Bluebird Care (Manchester South)

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 20 October 2016 and was announced. We gave the provider 48 hours' notice as they are a domiciliary care provider and we needed to make sure there would be staff in the office. On 24, 26 and 28 October 2016 we contacted people who received a service and relatives to discuss the service and gain their views.

The inspection team consisted of one adult social care inspector and one expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we asked the provider to complete 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. This was completed and returned within the required deadline.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We also spoke with the local authority commissioners for the service, the local authority safeguarding team and Healthwatch. Healthwatch England is the national consumer champion in health and care.

We spoke with seven people who used the service and three relatives. We also spoke with the director, registered manager, care co-ordinator, two supervisors and two care workers. We looked at the care records

for four people who used the service, medicines records for five people and recruitment records for four staff. We also looked at records about the management of the service, including training records and quality audits.

Good

Is the service safe?

Our findings

People and relatives we spoke with told us they felt safe with the support provided by care staff. One person said, "It's excellent; I feel safe." Another person told us, "They (staff) are very good; I have no qualms about them." Other people commented about feeling safe using words such as "definitely" and "entirely". One relative commented, "Yes, I feel [family member] is safe."

Staff had a good understanding of safeguarding issues and were confident in identifying potential safeguarding concerns. Staff were also able to explain the reporting process to us. One staff member we spoke with said, "Firstly I would report it to my manager here but if it kept happening I would report it to CQC (and follow the whistleblowing procedure)." Another staff member told us, "I would report to my manager. I haven't seen anything of concern."

There was a safeguarding file available that included details of all safeguarding concerns identified, alerts raised to safeguarding local authority, investigations and the subsequent action taken. Safeguarding records reflected those notified to the Care Quality Commission (CQC). Records showed safeguarding concerns were investigated and outcomes communicated to the person involved, if appropriate, and all other relevant parties. Actions included disciplinary action towards staff and referrals made to the disclosure and barring service.

People had risk assessments in place where required. Risk assessments were stored within care files and were regularly reviewed by the care co-ordinator or supervisors. All identified risks had appropriate care plans in place which detailed how people should be supported to manage those risks. For example, use of specific equipment to assist people to mobilise.

In addition to risk assessments around people's individual needs there were also risk assessments around the internal and external environment of people's homes. For example, risks identified included loose paving stones. The measures in place to minimise potential risks were recorded. For instance, smoke detector locations and when they were checked. Potential escape routes for people in the event of an emergency were also detailed. Records of dates when equipment was serviced and when the next checks were due were recorded and checked during the next six monthly reviews.

Records of accidents and incidents were recorded in appropriate detail. Records included details of those involved, what had happened and details of action taken following an incident or accident. During the inspection we noted there had been four incidents or accidents recorded about people receiving a service. Records included a fall a person had experienced, a fire in a person's home and events when people had demonstrated behaviours that challenge. Actions recorded included contacting paramedics, other health professionals and police and referrals to the local clinical commissioning group (CCG) to seek a more suitable service following the changing needs of a person.

Medicines were administered safely and appropriately. All medicine administration records (MARs) were completed fully with any reasons for non-administration recorded. Staff competencies were regularly

assessed by the registered manager, care co-ordinator or supervisors to ensure those administering medicines were skilled to do so safely. Regular medicines audits were carried out by the registered manager and care co-ordinator to identify any medicines errors.

Records in staff files demonstrated staff were recruited with the right skills, experience and competence. Recruitment checks had been completed before new staff started working with vulnerable people. These included checks of their identity, occupational health, reference checks and a disclosure and barring service check (DBS). DBS checks are used as a means to assess someone's suitability to work with vulnerable people.

People and relatives told us there were enough staff to meet people's needs. One person said, "Yes there are enough staff. Even the managers have come when they are short staffed." We viewed a selection of electronic rotas to check that enough staff were deployed to calls. Each rota contained a list of carers with times of calls. We saw that people had a consistent cohort of carers where possible. The care coordinator told us that they tried to organise rotas so people were supported by the same team of care staff. This only changed if there was sickness or holidays or if people requested specific staff to provide support. One person said, "We do sometimes get the same ones (care workers). We might see the same ones two or three times a week." Another person told us, "Yes there is good continuity; you see the same ones. There might be the odd new one." A third person commented, "It's usually the same girls."

Relatives had similar views on the continuity of care from consistent staff members. One relative said, "[Family member] needs continuity. She has mainly one regular carer. But there are two or three; she knows them." Another relative told us, "There are usually two regular staff but there is a team of four." A third relative commented, "Yes, it's not bad, there is some continuity. The same ones (care workers) come regularly."

Good

Is the service effective?

Our findings

People and relatives told us they felt staff were trained to provide care to meet people's needs. One relative said, "They (staff) have been trained before they come (when supporting their family member with the hoist)."

All staff received a structured induction at the beginning of their employment which then led to the care certificate. The care certificate is a set of standards that social care and health workers work to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers. The registered manager told us and records confirmed that new staff received a basic three day induction delivered internally by management. The induction included all mandatory training and a full shift shadowing experienced staff. Shadowing was observed by the supervisors who assessed the practical delivery and approach staff had towards people and the support they received. The registered manager explained that one full shadow shift was the minimum for new staff but more would be completed if required, depending on their performance.

One staff member told us, "I had an induction yes. I've had training in (areas such as) moving and handling, safeguarding, confidentiality. You then go on shadow shifts; they introduce you to the client, read the care plan so you can know more about the person." They went on to tell us, "You do a minimum of three shadow shifts. It depends how comfortable and confident you feel. Three was enough for me because I worked in care before."

Records showed staff had received up to date training in all appropriate areas such as safeguarding, moving and handling, medicines, food hygiene, health and safety and mental capacity act 2005. The registered provider had a commitment to supporting staff training and developing staff to improve service delivery as well as career development. The director told us, "Our aim is to promote staff learning and allow staff to be involved in shadowing and mentoring (when appropriately experienced to do so). We don't want staff to be static." They went on to explain initiatives and strategies they had in place to support staff to develop further in their careers such as encouraging staff to explore alternative training or aspire to shadow staff in higher positions in order to gain experience.

Staff told us they received enough training to equip them to carry out their roles effectively. When asked if they received adequate training one staff member told us, "It's enough, yes." They'd just received their three month review and went on to tell us, "[Registered manager] has just advised me to do the care certificate, so that's what I'm going to do."

Staff told us they felt supported in their roles by management. One staff member who was fairly new to the service said, "This was my second supervision in six weeks." When asked if they found it useful, the staff member told us, "It is because at least you can reflect and have discussions and they can feedback and tell you if you're doing a good job or not."

We viewed supervision records that confirmed staff received regular supervisions. Discussions covered a

range of areas including how staff felt in their roles, positive or negative feedback from spot checks, reminders of new procedures and training.

The registered manager told us and records confirmed that they also completed informal telephone supervisions with staff around specific areas. Particularly for staff who were new and for staff who were unable to attend scheduled supervision meetings. The registered manager said, "We wouldn't want to skip someone's supervision because they couldn't get into the office so we sometimes do telephone supervisions as well." As part of the supervision process direct observations were carried out on staff members to assess their performance around interaction with people. This meant the service had alternative methods to ensure staff felt supported in their roles and received necessary supervision and guidance.

The provider had a policy and procedure in place for each staff member to receive an annual appraisal. Records viewed included discussions around what was working well, which areas could be developed, additional support that would benefit performance, training and development requirements and any other comments staff had. Appraisals were completed annually and included training needs as well as training goals of staff. Records were up to date and signed by staff members and management.

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.

At the time of the inspection people had capacity to make decisions about their care. The registered manager explained that some people were supported by relatives to make decisions around their care. They also told us if they suspected people lacked capacity to make important decisions they would refer them to the local authority for a MCA assessment. They would then arrange a best interest meeting in order to make decisions around people's care. The registered manager went on to explain decisions would be made in people's best interests, involving them where possible as well as their relatives, advocates and appropriate professionals such as social workers.

One staff member said, "We support people to make decisions. We tell them there's this or there's that (giving them options of food and clothing for example). We ask 'do you want me to do this? Care plans also contain people's preferences." Another staff member told us, "All clients I support have capacity to make decisions and give consent. But I would check care plans before support to make sure they could (consent or make decisions)."

Some people had been assessed as requiring support to meet their nutritional needs. Where necessary, people's care records contained nutritional care plans. These detailed how staff were to support the person and contained their individual preferences, likes and dislikes. For example, '[Person] likes toast or cereal for breakfast.' Records also included instructions for staff to ask people what they wanted and included information of usual meals such as hot meals on a lunch time or sandwiches using fillings from the fridge.

People had access to external health professionals and were supported by staff to make appointments as

and when required. Records confirmed people had regular input into their care from a range of health professionals including GPs, district nurses, specialist nurses and occupational therapists.

Good

Is the service caring?

Our findings

We spoke with people about whether they thought the service was caring. They told us they were happy with the care they received at the service. One person said, "They (staff) are lovely in every way. I couldn't have a nicer team." Another person told us, "They are very polite; we always have a laugh, always." A third person commented, "They are very nice. They settle themselves (into the person's home) and they are friendly."

People and relatives we spoke with felt listened to and that staff treated them with respect and dignity while supporting them with personal care. One person we spoke with said, "Definitely, of course they treat me with respect," When we asked another person if they felt staff treat them with dignity and respect they said "absolutely". A relative told us, "They respect [family member's] wishes. They are respectful." Another relative commented, "Yes, they (staff) are kind and gentle (when supporting family member)."

Staff told us how they ensured people's dignity and privacy was maintained. One staff member said, "If you're giving someone a strip wash you cover other parts, ask if they are okay with you washing particular areas. I close curtains or blinds and close doors." They went on to say, "Just because someone is bed bound doesn't stop them knowing and consenting to or refusing (support)."

Staff supported people to meet their individual needs and preferences. One person said, "Sometimes they do more. Two particular ones (care workers) are kind. They do their best. I don't know what I'd do without them." Another person told us, "They cook for me. They do toast and put an egg on. They microwave for me and they do my drink of tea." People and relatives told us staff did everything they were supposed to and sometimes more. For example, if someone was feeling unwell.

Staff were issued with a handbook on commencement of their employment which included information and guidance about the service. Induction training was delivered to staff which covered privacy, dignity and confidentiality. The service also had policies and procedures in place for staff to access.

Staff supported people to help them maintain their emotional wellbeing. People's needs had been assessed and appropriate plans of care had been implemented to guide staff how to support people's wellbeing. We viewed people's electronic care records and noted staff recorded daily notes. Records included details of support provided as well as people's mood and conversations staff had with people. For example, if they had any issues or concerns. One relative we spoke with told us their family member had an issue with a member of staff. They spoke to other staff and the care worker in question ceased providing support for the person.

People were supported to be as independent as possible. People accessed the local community with staff support, with tasks such as shopping and health appointments as well as activities to meet their social needs.

Staff had instant access to information in people's care records about their needs and preferences, including their likes and dislikes. For example, one person's care plan stated, 'I would like you to wash the

top half of my body. I will wash my own hands and face.' People told us staff asked them specific questions relating to their care and support. For example, what they wanted to eat at meal times.

At the time of the inspection no one was receiving a service from an advocate. The registered manager told us about a time they had previously supported a person and their relatives to access an appropriate advocate. The registered provider held information for a variety of advocacy services and assured us they would support people to access appropriate services if needed.

Good

Is the service responsive?

Our findings

People told us they received the support they needed and sometimes staff went the extra mile. We asked people if they felt staff knew them well. One person said, "Yes they do; they are very nice." One relative said, "It's unbelievable how good they are." Another relative told us, "They respect [family member's] needs. They respect [family member's] choices."

People had a range of care plans in place to meet their needs including personal care, nutrition and hydration, medicines and mobility. The registered provider used an electronic system for care plans and risk assessments. All staff were provided with a mobile phone device to ensure they could instantly access people's care plans and other records even prior to entering a person's home. One staff member told us, "The pass system is really good." They gave us a demonstration of the system on their phone and said, "You can look at people's care plans before you go to their house."

The care co-ordinator demonstrated how they used the electronic care plan system and the variety of functions available. They explained that people and their relatives were able to access the system by obtaining a password from a member of the office staff. They gave an example of a situation when a relative was able to check their family member's care plan records and details. They were able to contact the care co-ordinator directly through the system to inform them that their family member's GP had changed, providing the details for the new GP.

The care co-ordinator went on to explain how people had a magnetic strip in their care plans which staff scanned with their phones. This function then automatically updated the system with the date and time of the staff member's arrival to the person's home. Staff then used the application on their phones to check people's care plans and record all engagement and interaction, including medicines administered, personal care provided and people's general mood.

Care plans contained adequate detail and guidance to inform staff about how to provide the support people needed. For example, one person's nutritional care plan stated. 'I would like a hot meal of my choice, in the lounge where I like to sit and eat my meals. I will tell you want I want. I will have a drink of my choice.'

Care plans were reviewed on a regular basis, as well as when people's needs changed. All care plans we reviewed were up to date and reflected the needs of each individual person. People told us they felt in involved in the planning of their care. One person we spoke with said, "Yes, we've had a review. They came and said we have questions about your care." Another person told us, "We talk about (my care)." A third person commented, "If I need change I go the manager." A relative we spoke with said, "Yes, we have (care plan review meetings). We do them together (with their family member and staff)." Another relative told us, "If we want to change the pattern of care, we have a care plan review."

Staff could also access their individual working rotas through the application on their phones which meant any changes or updates to rotas were immediately available to staff. Any aspects of people's care not provided was flagged up on the system, staff then had to record the reason why support wasn't provided.

For example, the person refused, was unwell or was not home when they called.

We asked people if they had any complaints about the service and if they knew how to complain. One person said, "I have no concerns. I couldn't wish for anyone nicer." Another person told us, "Nothing at all. They go over the top, they are too good. One of the carers stopped on her way out and helped me bring the washing in." We asked another person if they felt they could tell staff if they were unhappy with the way staff did things and they said, "I could tell them if I wanted."

A relative told us, "I would discuss it (a problem) with staff before I went anywhere else. I'm very happy (with the care.)" Another relative said, "I know how to call them (management, if they had a complaint). It's in the paperwork."

The registered provider maintained a record of all complaints received and subsequent action taken. Records showed the registered manager had investigated the complaints, recorded all action taken and fed back to complainants. Any lessons learned were recorded and communicated to staff through staff meetings, carer group meetings or individual supervisions. Actions recorded included safeguarding referrals and changes in practices. The registered manager completed a monthly analysis of complaints received to identify any trends and areas of concern.

Good

Is the service well-led?

Our findings

People and their relatives told us they were happy with the service they received and that it was well led. They felt that the provider was approachable and felt confident in the organisation of the support they received. One person told us, "It's excellent." Another person said, "I can recommend them." A relative we spoke with told us, "We have been very satisfied." People and relatives also told us they felt listened to and that the service was very good at communicating and keeping them updated.

The registered manager told us they operated an open door policy at the service to enable and encourage staff to approach either themselves, the care co-ordinator or the supervisors with any requests, concerns or issues and requests for any guidance. Staff told us they could approach management whenever they needed to. One staff member said, "Yes they are very approachable and sometimes they go beyond to try to make arrangements to best suit and support staff (without impacting on people)."

Staff told us management operated an open door policy which made them feel supported. One staff member said, "Your supervisor is just a phone call away. They are very supportive and I know I can just pick up the phone and call to ask anything." During the inspection we observed staff members visiting the office to speak with management. This meant staff had access to senior staff as and when required and felt comfortable approaching them in the office.

We asked staff what the registered provider and service did well. One staff member said, "They listen to you and they try to work around each individual." Another staff member told us, "How approachable and how helpful they are. Whenever you have a problem you know there's always someone at the end of the phone."

Staff told us they felt the service was very caring and they really enjoyed their jobs. Staff spoke about their role as care workers in a compassionate way. One staff member told us, "I am (happy in my role) at the minute, so far." Another staff member said, "Oh yes, very much," when asked if they were enjoying their role.

Staff told us they couldn't think of anything the registered provider could do better. When we asked them one member of staff said, "Nothing as far as I know at the minute. I've been with them for six weeks and I don't have any problems."

The home had an established registered manager who had been in post since October 2015. During our inspection we noted that one statutory notification had not been submitted to the Care Quality Commission. The notification related to a person who had suffered a fractured hand following a fall in their home. We discussed this with the registered manager who explained it had been a misunderstanding on their part. The registered manager informed us that the person had not shown any signs of pain and was checked by staff following the incident. The person attended hospital later that evening with a relative when their hand became swollen. Statutory notifications had been received in relation to other areas both before and after this instance. The registered manager acted immediately and submitted the notification to the Commission. We are dealing with this outside of the inspection.

The service had out of hours arrangements in place to ensure staff members were able to contact a member of the management team if necessary. The registered manager informed us that out of hours arrangements were organised on a weekly rolling rota between themselves, the care coordinator and the two supervisors. The allocated senior person covering had the out of hours mobile phone which staff had the contact number for. If staff contacted the office outside of normal hours an answering machine message would inform them to contact the mobile number.

The director told us about a staff incentive scheme they had recently introduced which saw individual staff member's receiving a 'carer of the month' award and a prize. The nomination process was internal and by management staff only. However, the director informed us it was a new scheme and they were exploring ways to involve people who receive services and their relatives in future to be more reflective of people's views, not just management.

Supervisors carried out random spot checks on staff in people's homes. Checks included whether they wore the appropriate clothing and identity badges, timekeeping, customer approach, food safety and if they followed infection control protocol. Other areas included moving and handling and documentation. From the spot checks we viewed, there were no actions required. The registered manager assured us that any actions identified would be discussed and followed up with the member of staff during the supervision session that followed the spot check.

When discussing receiving spot checks by member's of management, staff told us they found the process useful and supportive. One staff member told us, "It's more like help and reassurance is coming (rather than being tested). I feel reassured always." Another staff member said, "They (management) come and spot check and do a supervision at the same time."

Staff had the opportunity to give their views through attending regular staff meetings. We viewed minutes of staff meetings and noted discussions around people, shift patterns, policies, procedures, training and the electronic care plan system. We noted from minutes that discussions took place and appropriate action was taken. For example, staff informed the meeting they felt they weren't getting a sufficient rest break during double shifts. The registered manager discussed this with them and agreed an increased break between shifts. This meant staff's views were encouraged, considered and listened to.

The service also held regular senior team meetings to discuss areas to monitor and continually improve the quality of service provision. Discussions included any issues or concerns or potential risks, complaints, training, feedback from spot checks, on call arrangements, feedback from people and policies and procedure updates or reminders. Minutes of meetings showed discussions and any agreed actions. Updates of action taken were discussed during the meetings that followed.

Newsletters were created regularly and circulated to all staff to keep them informed of things happening in the service. The registered manager informed us that they try to send newsletters out on a monthly basis but as a minimum send them out quarterly. Newsletters contained information such as points of feedback from staff and action taken, emergency on call arrangements, medicine compliance and policy updates. We noted from the June 2016 newsletter staff were informed that the whistleblowing policy had been recirculated to them and reminded them to contact the office if they hadn't received a copy for whatever reason. The newsletter also gave praise to staff for the excellent work they did stating, as a provider, they were 'proud to have a loyal and hardworking workforce'.

The service had received a number of compliments and thank you cards from people receiving a service or

relatives of people who had previously received a service. One letter received from a person receiving a service stated, 'The carers are very prompt arriving, are friendly and always have a smiling face. The carers do what I ask them to do and everything is fine which gives my family peace of mind that there are people here that can help.' Another compliment received from a person receiving a service stated, 'Since starting with bluebird care the service has been very good. All the staff are lovely and all match my outgoing personality. I appreciate all the help and support I receive which lets me live independently.' A message received from a relative stated, 'We can't thank bluebird enough, the dignity they shown to my late [family member] and our family. Lovely caring company who always went the extra mile. One of the carers even attended my [family member's] funeral and they only looked after them for a week and the same [staff member] still calls to see my [family member's spouse]. Bluebird is worth every penny for our experience.'