Most Stars Limited

Bluebird Care (Rother & Hastings)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place between the 12 and 19 June 2018 and was announced. This means the provider was given notice due to it being a domiciliary care service and we needed to ensure that the registered manager and staff would be available.

Bluebird Care is a domiciliary care service. It provides personal care to people living in their own houses and flats in the community and in some specialist housing. It provides a service mainly to older adults and some younger adults with specialist needs. The service supports people in Rye and the surrounding areas. The service also provides live in carers to give relatives a respite from their caring responsibilities. At the time of inspection 43 people were receiving the regulated activity of 'personal care'.

The service had a registered manager in post. A registered manager is a person who is 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.

At our last inspection in 2017 we rated the domain of 'Safe' and 'Well led' as requires improvement. Three recommendations were made in relation to good practice regarding staff knowledge of escalating safeguarding concerns, accident reporting, and processing references for new staff. At this inspection we found that the provider had made improvements in these areas.

We found that a safe recruitment process was in place to check the suitability of staff but minor improvements were needed to ensure the completion of some documentation. We have made a recommendation regarding staff recruitment records.

Medication was managed safely but auditing could be improved by extending the practice of dating liquid and ointment medicines to boxed medicines and this is an area for improvement.

A range of audits had been developed to inform the registered manager and provider of where the service was operating well and areas that needed attention, the audit of staff records however, is an area for improvement..

Staff understood their responsibilities for the protection of vulnerable adults, and how to escalate suspicions and concerns both within and outside the organisation. Action had been taken to improve the accident /incident reporting process; peoples care records could be accessed remotely by office staff that monitored and audited records to alert them to any omissions in recording and reporting. The registered manager analysed accidents and incidents for patterns and trends, and reviewed actions taken.

There were enough staff to support people's day to day needs, staff and people said they were never rushed; there was good continuity of staff and no missed calls. People and relatives spoke positively about the

reliability and dedication of staff. A suitable system was in place for the assessment and management of risk to keep people safe. Guidance was provided to inform staff how to support people when they became over anxious to de-escalate their behaviour and reassure them.

Staff had been trained in infection control and prevention and implemented this in their daily practice. New staff received an induction to their role before working unsupervised; all staff received regular training updates to enhance their knowledge and skills. Staff felt well supported and found the registered manager and office team approachable. Arrangements were in place for regular staff supervision and annual appraisal of their performance and development.

People referred to the service were assessed before a decision was made to accept the care package to ensure this could be met, the assessment took account of any additional support people may need regarding their sexual orientation, ethnicity, culture, or religion and this was recorded in the care plan to inform staff. Each person had a plan of care that was developed with them and their relatives. This guided and informed staff in the tasks they undertook for each person. Office staff reviewed care records daily to ensure needs were supported in accordance with care plans and preferences and were kept updated. People received a copy of their updated care plan. Formal reviews of care plans were conducted on a six monthly cycle with complex cases reviewed more frequently. The registered manager and office staff were aware of changes to Data Protection Law and people and staff records were kept securely.

Staff were mindful of those people who could be nutritionally at risk or from poor hydration and took appropriate action to support them with meals and extra drinks. Staff supported people with their health appointments where required, they monitored people's health and referred them appropriately for additional health support when needed.

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's capacity to consent was assessed and recorded in their care plans.

People and relatives were complimentary about the staff and the quality of service provided, they felt listened to. Their views were sought and were influential in service development. Staff encouraged people to remain as independent for as long as they wished to be, and supported them to maintain a community presence if that was their wish. People told us that staff were kind and caring and treated them with respect and dignity. People were supported to retain their independence; care plans made clear what people could do for themselves. Peoples sensory and communication needs were documented and information provided in an accessible format if required. Staff supported people with social inclusion who wished to continue with activities they enjoyed such as shopping or attendance at events. People and relatives felt able to approach staff with any concerns and those who had thought these had been handled to their satisfaction.

Where known peoples end of life wishes were recorded. The service provided people with palliative and end of life support and this was well thought of by health professionals.

People and staff found the registered manager and senior staff approachable and supportive, staff received regular supervision and assessment of competency, Annual appraisal was carried out for those in post for more than one year. Staff were kept informed by emails of care plan changes, and policy and procedures updates they needed to be aware of if this informed everyday practice. Staff visited the office on regular occasions to make use of the facilities and to liaise with office staff. Staff were assessed individually in the community, whole staff meetings were held on occasion and staff were confident of raising issues within these and that they would be heard and issues addressed.

The provider made use of new technology to enhance the productivity and effectiveness of staff; this enabled remote monitoring daily to ensure people received timely care in the way they preferred. They have kept the Care Quality Commission appropriately informed of any notifiable events. They have developed good working partnerships with health and social care professionals and are well thought of. They have developed a community presence and have engaged with the local community through events.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was safe but minor improvements were needed

Medication was managed safely, but opening dates on boxed and bottled medicines would aid audit processes.

A satisfactory recruitment process was in place, but gaps in employment histories needed to be fully addressed. There were enough staff to meet people's needs.

Staff knew how to recognise and respond to abuse. Individual, environmental and infection control risks were managed appropriately to keep people safe.

Is the service effective?

Good

The service was effective

Staff received the necessary training, support and supervision to carry out their roles effectively.

Staff understood and worked to the principles of the MCA 2005 seeking consent and supporting people to make choices...

Staff ensured people at risk of poor nutrition and hydration had drinks and snacks available throughout the day.

Staff supported people to contact health care professionals if they became unwell, or if there were concerns.

People were assessed prior to commencement of care which took account of any equality and diversity issues might need to be aware of.

Is the service caring?

Good

The service was caring

Staff understood the needs of people they supported.

Staff demonstrated kindness, patience and a willingness to do more to make peoples experience of support good.

People and relatives were kept informed and felt involved.

Staff respected people's privacy and dignity in the delivery of care and support.

Is the service responsive?

Good

The service was responsive

People were consulted about their care and support, and involved in the development and review of their care plans.

Information was provided in accessible formats and care plans recorded people's communication and sensory needs.

People knew how to complain and were confident and trusting that their concerns would be listened to and acted upon.

Peoples end of life preferences and support needs were documented where these had been provided.

Is the service well-led?

Requires Improvement

The service was not consistently well led

A range of audits were in place to provide the provider and registered manager with an overview of service quality, and where improvements could be made. We have recommended the audit of staff files is strengthened.

People using the service, relatives and health and social care professionals commented positively about the leadership of the service.

People and relatives were given opportunity to comment about the service and these influenced service developments.

Bluebird Care (Rother & Hastings)

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.

Inspection site visit activity started on 12 June and ended on 19 June 2018. It included visits to three people in their own homes. We visited the office location on 12 June 2018 to see the office staff and interview three care staff, and undertake home visits. We reviewed care records and policies and procedures. We visited the office location again on 19 June 2018 to meet with the registered manager and the provider and to review staff recruitment, induction training and supervision records, accidents and incidents, quality audits and surveys. The provider was given 48 hours' notice because the location is a domiciliary care service and we needed to be sure that someone would be at the office. The inspection was carried out by one inspector.

Post inspection we spoke with an additional two people and four relatives via telephone and received feedback from three health professionals that know the service well.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We looked at the previous inspection report and any notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

We spoke with the provider, the registered manager, and two care co-ordinators of the service. We spoke with three other members of staff. We looked at three people's care plans and the associated risk assessments and guidance. We looked at a range of other records including three staff recruitment files, the staff induction records, training and supervision schedules, staff rotas and quality assurance surveys and

audits.

Requires Improvement

Is the service safe?

Our findings

People told us they found the service very reliable, calls were never missed and there was good continuity of staff. People had trust in staff and felt well supported by them. People told us, "They know how to care for people properly" and "My husband has a live in carer and is looked after extremely well, nothing is too much trouble for them". Another person said "I know if something deteriorates they would call me if they were concerned or think she is unsafe".

At the previous inspection in May 2017 we found a shortfall with references in one file that was partially resolved at that inspection. At this inspection we found there was a well-structured recruitment and selection process in place. Staff told us that they had completed all of the checks required before they started working in the community such as the Disclosure and Barring Service (DBS) criminal records checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care services. Staff files showed confirmation of these checks together with other relevant checks such as proof of identity, health statements, employment and character references and previous employment history.

Some improvements were needed to strengthen the present recruitment process. This was because on one file a second reference was outstanding this was an oversight as; other files viewed showed it was usual practice to re request references if they had not been received. Employment histories were in place but there were some unexplained gaps on each file viewed. Interview records were not routinely maintained to record if reasons for gaps had been explored at interview. A structured interview question and recording format was available, but not used by the registered manager who used her own format. This was because she wished to assess the skills and values of applicants which she felt the current format did not adequately address. The registered managers' interview format however was not recorded so there was a risk that this could alter between interviews and applicants may not receive equal opportunity in the interview process; the registered manager agreed to formalise this process.

We recommend that the provider review the existing recruitment process with the registered manager to assure themselves that procedures are being adhered to and file documentation is complete.

There was ongoing recruitment to ensure that there was enough staff to meet people's needs and preferences. In response to feedback from people and relatives, the decision had been taken to no longer use staff from other agencies to cover calls at times of staff shortage. All calls were now covered in house for sickness and annual leave and this provided continuity of staff for people. Staff said there was a good sense of team work and staff were more willing to cover calls. Staff were paid for travel time and the co-ordinators arranged visits as geographically close as possible to reduce the travelling time between calls. Staff said they never felt rushed. The registered manager said that retention of staff was improving and provided better continuity of care to people. The service had a 'no strangers' policy which meant that in 90 % of cases new staff were always introduced to those people who they might be asked to cover at some later date. People and relatives spoke appreciatively about the staff that called and the relationships they had built with them. They said how supportive they found them to the person and the wider family. People said staff arrived

mostly on time and stayed the time they should. They completed the tasks they needed to but always asked people or relatives if there was anything else they could do.

There was an out of hours on call service for staff or people and relatives to call in emergencies. The on-call service was covered by the registered manager and co-ordinators. A staff member told us, "The on-call service works well; I have used it at weekends before." A continuity plan was in place to ensure that home visits were covered in emergency situations such as bad weather. A traffic light system was used to prioritise calls to those most at risk.

Medicines were managed safely. Staff were trained to administer medicines and their initial competency assessed prior to them being allowed to administer unsupervised. Some people had their prescription orders arranged by the service so that supplies were available. For people who had lost capacity around administering their medicines staff made sure medicines were securely stored away before they left. Medicine administration records (MAR) were electronic and a highlighted alert was shown when medicines were not given or signed for. Co-ordinators could monitor and audit daily notes and MAR entries remotely. This enabled them to check medicines had been administered appropriately or identify action needing to be taken to address any errors. A record of people's medicines was kept within the electronic care records so the provider and office staff had oversight of what people should be taking and could query any anomalies.

Medicines records were updated as changes occurred. Staff were informed by internal email of changes to people's needs including medicines changes. Permission was sought from health professionals and through best interest discussion if a medicine needed to be crushed to be administered. Staff understood how to deal with spoiled medicines and return them to the pharmacy. Body maps were used to inform staff where prescribed creams needed to be applied. Staff understood and implemented good practice around administration of pain patches. An individual protocol was in place for when people needed to have as and when required medicines administered, this explained to staff about when these medicines should be taken. The registered manager was aware of The National Institute for Health and Care Excellence (NICE) guidelines on 'Managing medicines for adults receiving social care in the community.' These informed the providers' medicines policy and procedures. It is good practice for medicines that are not contained in pre packed dosage systems to be dated when opened, staff were doing this for liquid medicines and ointments and needed to extend this to boxed medicines if and when they received them, this is an area for improvement.

Suitable arrangements were in place to assess, manage and reduce risks to people's health and safety so that they consistently received safe care and treatment. Known risks people were likely to experience from their environment or from their own specific needs had been assessed and control measures put in place to mitigate them. Moving and handling risk assessments detailed the equipment and numbers of staff needed to manage this safely. A system was in place to ensure equipment used in people's homes was serviced appropriately to protect the safety of the person and staff. Care records detailed the actions staff needed to take to reduce risks such as strategies for de-escalating behaviours that challenge, securing medicines out of the way to avoid harm, leaving people drinks and snacks, or ensuring mobility equipment was placed near them. Staff reported changes in risk to office staff who notified relevant people including relatives, social services, GP or the mental health team. This could lead to a review of risk and whether this might require additional resources to keep the person safe. Lessons learned from an incident at a person's home had led to a staff member being appointed fire champion. Their role was to routinely visit every person to check on their smoke and carbon monoxide alarms, to ensure they were in working order. Any concerns about fire safety were referred to the local fire service, who would undertake an assessment visit of fire risk, with the person's permission.

Staff had received training in infection control and health and safety. Personal protective equipment (PPE) such as disposable gloves and aprons were available for staff to use when providing personal care. This helped to prevent the spread of infection.

Staff had received training in safeguarding adults and children. They demonstrated a good understanding through training and personal experiences in their work of the different forms abuse could take, and who might perpetrate this. They understood their own responsibilities to act and report on any suspicion of abuse. They knew how to escalate their concerns both within the service and to external organisations, to ensure an appropriate response was made. The registered manager was familiar with the safeguarding process and made referrals where concerns came to their attention from staff, or from relatives.

The registered manager analysed incidents and accidents. Lessons learned informed improvements to practice or risk assessment to reduce the likelihood of the same thing happening again. Records showed appropriate actions had been taken in response to initial incidents /accidents. Analyses was undertaken of how and why they occurred, and where needed referral to specialist healthcare professionals was made for assessment.

Good

Is the service effective?

Our findings

People and relatives said they found staff very professional and that they were confident staff knew what they were doing. Health professionals spoke positively of their partnership working with the service. One health professional said, "They are extremely responsive and will ring back ASAP to requests for joint visits."

New staff were provided with an induction linked to current national guidance, this included completion of some mandatory training such as moving and handling, medication, fire safety, food hygiene, infection control, first aid and safeguarding. New staff shadowed experienced staff until they felt confident to work unsupervised and they were assessed as competent. New staff completed a period of probation. Once completed and to enhance their knowledge and skills, staff were asked to undertake either the nationally recognised Care Certificate (this is a set of standards for health and social care workers) or an accredited qualification in Health and Social care.

A programme of refresher training enabled staff knowledge and skills to remain updated and relevant to meet people's needs appropriately. Specialist training from health professionals or other organisations was provided to staff working with people with specific needs, for example those requiring support with their Diabetes or the administration of medicines through a percutaneous endoscopic gastronomy (PEG) this is a tube that carries medicines and liquid nutrition for people who cannot swallow. Staff competency was routinely monitored through spot checks and observations completed by supervisors and senior staff. The registered manager was introducing a system of champions for a range of areas that would require those staff to receive additional training and to cascade and monitor good practice in areas such as safeguarding, infection control, health and safety, and dementia. A simulation suite had been developed, this was an accurate representation of much of the accommodation staff visited, and would be an effective and realistic location for staff to learn the aspects of the practical support they needed to provide in respect of all aspects of care delivery.

Staff enjoyed calling into the office where they could have a break in between calls and have informal chats if needed with coordinators or the registered manager. Each staff member had formal supervision approximately four times per year, or more frequently if needed. There were also observations of their practice conducted. Staff said they found these and the formal supervisions helpful, in informing their practice and gave them assurance that their work was satisfactory. Supervisions gave staff opportunities to discuss their training and career development, or issues that impacted on their work life balance. A system of annual appraisal was in place to assess staff development , training and performance, and to set objectives for the coming year .

The registered manager explained that all people referred to the service were assessed prior to a care package being offered. Any protected characteristics a person had in relation to their disability, sexual orientation, race, culture and religion were recorded at the time of assessment and included in the care plan. This informed staff of any additional support the person required in these areas. Staff had received training in equality and diversity and a policy was provided for them to read. Assessment entailed taking initial information over the telephone about the tasks that were required; a home visit was then arranged.

This process helped to inform the registered manager and senior staff as to whether they could meet the requirements of the person. On occasion this had meant turning a package down but the registered manager felt it was important to maintain the standard and quality of service people currently received. A health professional said they considered this type of response to show an embedded ethical base in the way the agency (service) conducted itself. A relative informed us, "There was an excellent transfer of care from a one agency (service) to another, when they transferred to Bluebird Care. They went on to say the planning that went into supplying staff for their relative was "really good and new staff were introduced before they started offering support."

Staff were mindful of those people who may be at risk from not eating or drinking enough. Those assessed as at risk had food and fluid charts completed daily to assess their intake. Their level of risk and tasks staff needed to perform to mitigate risk were documented in people's care plans for example, staff leaving extra drinks and snacks in accessible places for people between visits. Staff were tasked with checking for evidence of eating or drinking and to record their findings. People who were able were supported to make their own meals, staff cooked for others consulting with them about what they wanted to eat. Food supplements were given to people if these had been prescribed. Staff described successes they were proud of for example, getting people back to a healthy weight that had come to the service in a poor state of health.

Peoples health needs were supported. People spoke positively about the support they had received from staff in accessing some health care such as dental and GP appointments. The registered manager had developed Hospital passports for people which could be used to provide hospital staff with important key information if a person needed to be admitted to hospital.

A person told us that when their wife their main carer was unwell, staff had taken time to check on her wellbeing, and provided her with drinks. Staff monitored people's wellbeing, reported concerns to the office who alerted relatives and health professionals if needed. Individualised support plans were in place to inform staff about specific health needs such as Diabetes. These helped staff understand how the person's diabetes was managed and what they might observe if the person's diabetes became unstable; with the action staff needed to take. Staff made referrals where necessary to health professionals to arrange appointments for people causing concern to be seen. There were good working partnerships with a number of other health professionals particularly around palliative and end of life care such as community nurses, MacMillan and hospice at home services. A health professional told us "I really enjoy working with this care provider. (Name) the registered manager and her staff are easy to approach, always respond to concerns and queries. Communication is very good. We have worked closely on a very complex case. (Name) the registered manager led the process extremely well, and was key in ensuring the patient's needs were met; that all concerned were acting in his best interests, professionals and family included."

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. When people are living in their own home these applications must be made to the Court of Protection. No one was subject to an order from the Court of Protection.

The majority of people had capacity to make their own everyday decisions. People and the relatives of some people who lacked capacity told us that they signed care plans to show that they consented to the receipt or

delivery of care from staff. People told us that staff always asked them before undertaking a task. Staff demonstrated a good understanding of mental capacity and would seek advice from the office staff where they had concerns about someone's ability to make decisions. A record was kept of those relatives or friends who had a Lasting Power of Attorney (LPA). An LPA is a legal document where a person being supported can appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf. If the registered manager was unable to obtain this information from the parties involved they contacted the Court of Protection to confirm an appropriate authorisation was in place.

Good

Is the service caring?

Our findings

People spoke warmly and affectionately about the staff who came to support them, they valued their input and looked on them as friends. Relatives told us, "Staff are supportive of mum; they're polite and respect her," "They're superb they are very aware of my wife's needs" and "They're cheerful people they treat my relative in a really nice way, staff know how to help people they're not slap dash, no rushing, they spend time with people." A health professional said about the service "They pay so much attention to detail and to the client too."

People said they found staff kind and caring; they enjoyed their company and found them easy to talk with for a chat and a laugh. People and relatives said staff treated them and their homes with respect, and provided care to people in a manner that upheld their dignity and privacy. Staff said they were taught in their induction how to support people's personal care in an appropriate manner that ensured they were not made uncomfortable by the support staff offered. For example, covering them up with a towel when supporting them with personal care; making sure curtains or blinds were closed and that the person was fully consulted and involved in the task.

The registered manager said that a number of people supported were hard of hearing and it was therefore important that all staff had a good command of English; this was an important factor when recruiting new staff to ensure staff could be understood by the people they supported.

Everyone received a paper copy of their care plan which was kept updated. People and those relatives authorised to do so if they had a computer, could access their individual records on line. They were provided with a personal password to do so. Staff showed they were flexible in regard to this as one relative with computer access preferred paper copies of daily entries and staff arranged for this to happen. Staff demonstrated a good understanding of confidentiality, people were not aware of staff ever talking about other people they visited when they were offering support to them.

Written records kept within the office containing private information were stored securely when not in use. The registered manager and office staff were aware of recent changes to Data Protection Law with the new General Data Protection Regulation (GDPR); this new law regulates how organisations protect people's personal information. People's care records, were kept securely on the computers which were password protected and all documents were encrypted and sent password protected. Confidential paper records relating to staff were stored securely in locked cabinets.

Support staff were provided with phones that enabled access to people's computerised records to record tasks undertaken and record how people were at each visit. They, office staff and people and relatives had their own login to access particular parts of the computer system. This protected the security of records and ensured only those authorised to do so had access.

The agency service offered a personalised service and tried where possible match staff to people perhaps where there was a shared interest, for example horses, or cars. The registered manager was mindful of the

fact that all of the current staff team were women and people knew this and accepted this. However, to respect the fact that some people may have gender preferences for their support, they had recently consulted with people and relatives about this. They asked whether anyone had any particular objections to male carers if they were to be taken on. This was so they understood people's individual preferences and the likely take up. The registered manager was encouraged by the positive feedback from people which helped inform their future recruitment of staff.

People and relatives said they felt listened to and felt action was taken in response to their feedback on an individual basis and also in response to surveys.

People appreciated the continuity many of them enjoyed in the staff that supported them; they were kept informed of any proposed staffing changes through a computerised web roster.

Staff had a good understanding of people's individual religious beliefs and respected these.

People were supported to remain as independent as they wanted to be for as long as they wanted. The provider actively promoted people being able to stay in their own homes and to lead as normal a life as possible with staff support. A staff member told us "We don't get the shopping for them we take them shopping."

No one was currently supported by an advocate although the registered manager was aware of this service. A number of people had relatives who were actively involved in their care and support. Some had legal authority to be involved in making decisions in the person's best interest and the registered manager requested confirmation of this, where this could not be provided the registered manager confirmed relative's legal status with the court of protection.

People and relatives told us that they were actively involved in making decisions about their own or a relatives care and treatment. Records showed that staff liaised with people and relatives on a regular basis to keep them informed.

Good

Is the service responsive?

Our findings

People and relatives told us, "We've had a few hiccups but are happy with the way things have been sorted out," "I would always be happy to approach them with any concerns" and "They keep me informed, it's a good service."

Each person had a care plan that they or their relative had been involved in developing and continued to be consulted about as changes occurred. Care plans were personalised and covered all aspects of people's lives. They provided staff with a holistic picture of the person they supported, how they lived their life, who was important to them, what they could do for themselves and the areas where they would need support from staff. Morning and night time routines were recorded to guide staff support in accordance with people's individual preferences. A review of daily notes showed that staff were carrying out tasks in accordance with the care plans viewed.

People were supported by staff to live the life they chose and to maintain a presence in the community through attendance at clubs or classes, visiting the GP and going out shopping.

People received an information pack about the service when their care package commenced. The provider was meeting the accessible information standard because they took steps to make information in different formats if needed. They were able to provide peoples care plans in a font size and colour that suited their specific needs to make reading easier. People were also provided with passwords to access their records on line. The accessible information standard sets out a specific approach to recording and meeting the information and communication needs of people with a disability, impairment or sensory loss. People's needs in regards to their methods of communication or the impact of sensory loss were recorded in care plans.

A complaints procedure was in place and people were provided with a copy of this in their initial information pack. People spoken with said they had not had cause to raise a complaint but would have no hesitation in doing so if they felt it was needed. People said they felt able to talk with staff if they wanted things done differently. They said staff were always willing and offered to do other things for them if there was time. Complaints were recorded, investigated and responded to by the registered manager in a timely way and in accordance with the provider's policy. A small number of complaints had been received since November 2017; records provided evidence of a clear process and the outcome of the complaint with actions taken. All were resolved.

The service had a small palliative and end of life service receiving referrals from the Continuing Health Care team. Staff worked in partnership with local GP's, community nurses and hospice at home staff to ensure people received a positive end of life experience. At A small dedicated group of staff including the registered manager comprised the support team for people on end of life care; this helped to provide continuity in the staff providing care to the person receiving support in their final days, and also to their family members. There was recognition that providing support for people at this stage of their life was not something all staff would want to do. Only those staff comfortable with providing this intensive level of support and had

received training would be allocated to people to provide end of life care, as this aspect of the service grew.

The registered manager was actively involved in delivering end of life support and had personally stayed for three days at one person's home to support them through to their death. The registered manager explained that having received very positive feedback from health professionals about the end of life support care staff had been delivering there were plans for expansion of this area of the service. A relative told us, "I can't praise them enough". They spoke about how initially they were provided with practical care for their relative from the service. When their relative needed end of life care the staff then provided personal care. They said how they had appreciated the presence of staff, to not only care for the person but to provide emotional support for the other relatives. They told us that staff had sat through the night with their relative until they passed away. During this time they felt they had worked in partnership with staff who they felt had 'Taken a weight from my shoulders', and said they were very fond of all of them.

A number of people had made advanced decisions; this had been identified at the initial assessment and recorded in each person's file. Some people had also expressed end of life wishes and actions they would like staff to take if they found them deceased at a visit; this was recorded in their records.

There was a complaints procedure that people using the service received a copy of within their initial information pack. The majority of people and their relatives said they could not fault the service and had never needed to raise a concern, however if they had to they felt confident this would be handled appropriately and their concerns resolved. Complaints received by the service were minimal with only two received since November 2017. A record of actions taken was recorded and both were now resolved.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection we had noted some minor areas for improvement. No breaches of regulation were issued at that time. The impact of the shortfalls were considered to be minor on those using the service because staff had a clear understanding and knowledge about people's needs and their practice, and delivery of support was good. At this inspection we found there was still a need to strengthen recruitment processes to ensure staff records were complete in all areas or the reasons for not being complete were clearly indicated.

The frequency of care plan audits by the registered manager had improved to ensure that everyone supported had their file checked by the registered manager at least annually to ensure it contained all relevant information and was being kept updated. This was in addition to the six monthly reviews undertaken by office supervisors. It was clear, however, that where a significant change had taken place that impacted on staff delivery of care, the care plan was updated to reflect the change. Co-ordinators also monitored daily notes to ensure staff delivered care in line with the care plan and assessed needs. Medication was managed safely but the dating on opening of boxed medicines is an area for improvement.

A range of audits were in place to monitor quality of the premises, office files, customer satisfactions surveys, complaints and other documentation. Individual staff files were audited including staff induction, training, supervision and appraisal. This audit however needed to be completed more robustly regarding staff recruitment records. Gaps in employment histories of recruited staff, or actions taken in regard to chasing second references needed better recording to support the thoroughness of the recruitment process. This is an area for improvement.

People's individual files were audited to ensure all appropriate risk documentation; care plan, consents and financial information were in place. An office health and safety audit was conducted that looked at office fire arrangements and equipment servicing, and potential hazards and risks to staff and people visiting the office. The provider ensured that internal quality audits were conducted at least annually to identify potential areas for improvement and to develop an action plan for addressing these. With the exception of staff file audits the existing audit processes worked well to inform the registered manager and provider about how well the service was operating; they identified whether there were areas of service delivery that needed attention.

Health professionals, people using the service and their relatives spoke in a complimentary manner not only about the registered manager's leadership and 'on hands' approach but also about overall service quality. They indicated that they had confidence and trust in the registered manager and staff to deliver a high standard of care. Comments included "They provide high quality care and are extremely well led," "They're innovative, the simulation room they have developed for staff is an example of that," "It's well organised staff are personable and leadership is on the ball" and "The registered manager knows staff and clients well, she has an amazing in-depth knowledge of people, they go above and beyond." The provider was a visible presence and visited people weekly. People said they had an easy-going relationship with the registered manager and the registered manager was open to suggestions for improvement to the service .

The provider and registered manager had embraced new technologies that could reduce the time staff spent on paperwork, and enabled remote checking of electronic records. This provided greater assurance that calls were responded to within time frames, tasks were completed in accordance with people's preferences and medication administered. A variety of reports could be called off the computer system by the provider and registered manager to scrutinise aspects of the service and highlight areas for improvement.

In the provider information return received from the service they indicated that they had worked at engaging with the local community and having a real presence, by attending local events and raising money for local charities. They are proud of improvements they are making and have been praised in the local community for the innovation of the simulation suite for staff training. Management had taken their engagement with the local community further by demonstrating a willingness to help the local community when needed. A recent example of this was when there was a water supply problem to a warden controlled housing unit, staff from the service were sent around to deliver bottles of drinking water to the residents of that housing scheme.

A health professional commented, "They are one of the best care agencies I have worked with; when relatives tell us they are going with Bluebird Care we can have confidence in the arrangements."

The registered manager and senior staff were mindful of the wellbeing of their staff, and were flexible with the support staff needed. For example, a few staff were uncomfortable using computers, so for the few people those staff supported it had been agreed that paper copies of daily records and medication administration records would be maintained. These were returned to the office on a regular basis for auditing. Staff felt supported by the registered manager and felt able to approach her or the co-ordinators at any time. Staff meetings were held infrequently but staff said they felt confident of raising issues within these if they occurred. Staff drew most of their support from regular one to one supervision sessions, and an easy going open door culture that welcomed people using the service, relatives and staff to feel free to come to the office if they needed to discuss any issues or just for a friendly chat.

An annual customer survey was sent out. The registered manager analysed feedback from returned surveys and took action where possible to address any concerns. For example, recent feedback highlighted confusion from people about what staff meant when they referred to the 'care folder' that each person had in their home containing a copy of their care plan and some policy information. A standardised term was agreed with staff and people were informed of this. The format and style of the survey was also questioned and an alternative version was produced to give people the option of completing one of the other.

People told us that senior staff undertook home visits and telephone checks to ensure people were happy with the support they were receiving. Senior staff also undertook random monitoring visits to people who were supported to check staff practice and competency in carrying out the tasks they needed to provide in accordance with the care plan and policies and procedures. Several people told us they had experienced quality visits from senior staff.

The registered manager understood the need to inform the Care Quality Commission of notifiable events that occurred and had done so appropriately since the last inspection.

Staff were given access to where policies and procedures were stored; these documents were produced by head office and took account of current best practice. These were kept updated and staff were notified electronically when updates had been provided that they needed to read.

The registered manager and staff were aware of other organisations that might be supporting people they cared for. They had developed good working partnerships with a range of health and social care professionals to enable continuity in the support provided. The input of the registered manager and staff was valued by professionals. One health care professional told us, "I have always found Bluebird Care to be a very professional care service; they are always pleasant and approachable. I have had numerous contacts with them including telephone calls and more recently professional meetings where I have found them to be safe, effective, caring, and always responsive and a very well led service. I have never had any concerns about their service and therefore feel I can vouch for their integrity."

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed a copy of their inspection report and ratings in the reception area.