Somerset Care Limited

Realise South West

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Realise South West is a domiciliary care service which provides support to people in various locations across the South West of England. At the time of our inspection, the service was providing personal care to 45 people with learning disabilities, autism and assessed mental health needs, all people using the service were receiving personal care.

People's experience of using this service and what we found
People were protected from the risk of harm and abuse. Staff spoke confidently about actions they would take if abuse was witnessed or suspected. The provider identified and assessed risks to people and acted to mitigate these risks. Medicines were managed safely, and people received their medicines as prescribed. The provider ensured there were sufficient numbers of staff to meet the needs of people and was working to reduce their reliance on agency staff.

The provider operated a programme of checks and audits to monitor the performance of the service and submitted notifications to the commission as required. Staff were clear about their roles and spoke positively about colleagues and the management team. The provider worked with professionals and was involved with different initiatives aimed at improving care provision, both in the service and more broadly. Staff were proud of how they had supported people to reach their goals. Relatives said they had not been asked for feedback about the service and the provider was working to improve how feedback was sought. Relatives said they found communicating with the service was not always effective.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The provider was able to demonstrate that they were meeting the requirements and principles of Right support, right care, right culture. Person-centred care and risk plans were in place, staff spoke about and treated people as individuals. The provider recognised the importance of matching staff with people and that continuity of staff supported people to achieve good outcomes. Prior to the start of the COVID-19 pandemic, the provider had involved people with staff recruitment and aimed to continue this practice as soon as COVID-19 restrictions allowed. The provider was working with external professionals and organisations to improve care provision for people, both in the context of the service and more broadly.

Rating at last inspection
This service was registered with us on 17 July 2019 and this is the first inspection. The last rating for the service under the previous provider was good, published on 10 October 2017.

Why we inspected
The inspection was prompted in part due to concerns received about the improper use of restraint, medicines management and how the service was overseeing and supporting people with their finances. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. We found no evidence during this inspection that people were at risk of harm from these concerns. We found the provider had made an improvement to their process of managing peoples' finances. Please see the safe and well-led sections of this full report.

You can read the report from our last comprehensive inspection at the provider's old address, by selecting the 'all reports' link for Realise South West on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? Inspected but not rated	**Inspected but not rated**
Is the service well-led? Inspected but not rated.	**Inspected but not rated**

Realise South West

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team was made up of two adult social care inspectors, a medicines inspector and an 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.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 16 March 2021 and ended on 25 March 2021. We visited the office location on 23 March 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the

judgements in this report. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with the registered manager and care manager. We reviewed a range of records. This included people's care records and staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with eight relatives and four staff. We tried to speak with 10 people using the service, however people did not answer their phones or return our calls.

Inspected but not rated

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

Inspected but not rated

Assessing risk, safety monitoring and management

- Risks to people had been assessed and measures were in place to reduce these risks.
- People had individual risk assessments in place. We reviewed examples of management plans regarding environmental risks, accessing the community and risks relating to eating and drinking.
- There were systems in place to safely manage people's finances.
- Some people could become anxious leading them to harm themselves or others. There were detailed care plans in place giving staff guidance on how to respond to people at these times.
- Where incidents and accidents had occurred, action had been taken to minimise the risks of recurrence. Incident forms were completed and recorded on the provider's systems.
- Individual and personalised emergency plans were in place to ensure people were supported to evacuate their home in an emergency.
- Where people were at risk of choking or aspirating, assessments were completed by Speech and Language Therapists (SALT). We reviewed one care plan where information from the SALT assessment had been transcribed into the care plan. Although the information in the care plan was the same as the SALT plan, transcribing information increases the risk of an error. We discussed this with the registered manager who told us care plans would be reviewed to ensure this information was not transcribed into the care plans.

Staffing and recruitment

- The provider told us they had experienced difficulty staffing the service but worked to ensure sufficient numbers of staff were available to meet the needs of people.
- The provider engaged agency staff to maintain safe staffing levels and requested the same agency staff to improve continuity of care. Relatives said, "[Person's name] has a large team of staff. Unfortunately, [the service] are still using agency staff to the detriment of my son's mental health; he doesn't like new faces. It makes him anxious, agitated and likely to self-harm" and, "They are building the team up slowly so [person's name] gets used to the different staff gradually. Eventually, the team will do everything for them. It is still in the early stages and the plan is to add to the team again in May."
- The service was working to reduce their reliance on agency staff. For example, the provider had introduced measures to attract and retain staff, including supporting temporary staff to move into permanent roles. The provider was actively recruiting for additional positions.
- Relatives we spoke with were positive about staff. Comments from relatives included, "I feel confident in the staff. If anything is wrong, they let me know" and, "Everyone [staff] is pleasant and helpful. They are open, transparent and professional."
- Staff were recruited safely. The provider undertook relevant checks, such as those with the Disclosure and Barring Service and the applicant's previous employer. This helped lower the risk that unsuitable staff would be employed to work with people.

Using medicines safely

● Records showed that people had their medicines needs and risks assessed. Care plans recorded the level of support that people needed to receive. These were kept up to date when people's needs, or medicines changed.

● Records showed that people received their medicines safely and as prescribed. This included medicines to be taken when required.

● Staff were aware of the initiative 'stopping over medication of people (with a learning disability, autism or both)' (STOMP) and other prescribing initiatives. They worked in a person-centred way to reduce the use of sedative medicines where possible.

● Staff were trained and competent to support people to take their medicines. Medicines errors or incidents were followed up and learning put in place to reduce the chance of recurrence.

● Regular medicines audits were completed and some areas for quality improvement had been identified and actions put in place to make medicines administration safer.

Systems and processes to safeguard people from the risk of abuse

● The provider implemented measures to reduce the risk that people may experience abuse and acted when potential abuse was indicated.

● Staff knew how to identify potential abuse and spoke confidently about what actions they would take if abuse was witnessed or suspected. One staff member said potential indicators of abuse included, "If people are withdrawn or display different types of behaviour, are not themselves, have marks on their body or are flinching." The staff member confirmed they had received safeguarding training.

● The provider alerted the local safeguarding team to potential safeguarding concerns and investigated concerns when the need arose.

Preventing and controlling infection

● The provider implemented measures to help prevent the spread of infection.

● Staff were supplied personal protective equipment (PPE) and spot checks were completed to ensure staff were using and wearing their PPE in line with guidance and policies.

● The provider had identified that the use of agency staff could increase the spread COVID-19. To mitigate this risk, the provider sought assurances that agency staff would not be working in other services. The care manager said, "We have constantly and effectively responded with PPE drop offs at all hours of the day and, on one occasion at night, when the guidelines changed at the last minute".

Learning lessons when things go wrong

● The service had recently introduced an electronic care planning system that improved how staff could record and maintain records. For example, the system allowed staff to identify progress people were making in relation to their goals and enabled records to be updated in real time.

Inspected but not rated

Is the service well-led?

Our findings

This is the first inspection for this newly registered service.

Inspected but not rated

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● The provider undertook quality checks and audits to monitor the performance of the service and staff were clear about their roles. Statutory notifications were submitted in line with requirements. Statutory notifications help us to monitor services we regulate and tell us when notifiable incidents have occurred in a service.

● We inspected the service in part because of information of concern we received in relation to the use of restraint and the oversight of peoples' finances. We found no evidence that restraint had been used inappropriately or that peoples' finances had been mis-managed by the service.

● Staff we spoke with were confident about their roles and responsibilities in relation to people's finances and the potential use of restraint. Comments from staff included, "Restraint very rarely happens – there is a lot of withdrawing – staff step away when someone becomes heightened. There's a person-centred approach so it's different for each person… the person I work with its best to withdraw and use re-direction."

●Staff spoke confidently about how they supported people to manage their money safely. One staff member said, "[I] get a receipt, keep them all – book them on the system and [person's relative] collects them monthly." When appropriate, decisions about peoples' finances were made collectively. Speaking about how the service managed one person's finances, the registered manager said, "The social worker was involved in the decision-making process for this along with [person's name] advocate, and obviously his [relative] too".

● The provider had experienced technical issues regarding one person's financial records, causing the records to be lost. In response to this issue, the provider implemented changes to prevent a recurrence.

● Audits we reviewed included details of actions needed to rectify any shortfalls that had been identified, including who was responsible for completing the action and by when.

● The provider acted in accordance with relevant regulations and submitted statutory notifications to the commission as required. Statutory notifications help us to monitor services we regulate and tell us when notifiable events have occurred in a service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The provider was working to ensure people received a person-centred service.

● The service was proud they had sponsored the England Disabled Cricket team and people had been supported to join the team and play a cricket match. This was a charity event and all proceeds were donated to the team, of which one person was a member.

● Staff spoke positively about their colleagues and the management team. Comments from staff included, "The people I work with are wonderful – staff and people. The senior team is good, really supportive and

help out in an emergency."
● We reviewed various photographs of people being supported to pursue their interests. For example, one person was supported to spend a weekend away and participated in zip-lining, canoeing and abseiling.
● Staff spoke about people respectfully and in a person-centred way. One staff member wrote an account of how they had supported a person to get a car and had decorated the car with, "Balloons and ribbon" to make it, "Special." The staff member said the car had enabled the person to enjoy, "Trips to the shops, drives in the countryside and a trip to the seaside". One relative said, "They have got a Motability car for them. Now, she loves going out; she wants to go out all the time."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Relatives said the service could improve how they communicated with them. Comments from relatives included, "I find them good except they could communicate with the family a bit more" and, "Communication is not good. My contacts are with the team leader and the manager. Sometimes there is no reply, or they are late getting back to you. You seem to be constantly chasing for things from them. They are open to discussion once you get through to them and actions are taken once they have been engaged."
● Relatives told us they had not been asked to provide feedback about the service. We spoke with the registered manager about these comments who told us they had identified that methods they used to seek feedback from stakeholders, were not always effective. Prior to our inspection, the provider had explored different methods of seeking feedback and was implementing different ways of doing this, including using electronic surveys which could be accessed via a link.

Working in partnership with others
● The service worked in partnership with different organisations and professionals.
● The service was working with the local mental health team on a pilot project. The project involved developing a document that would enable accurate information sharing between care settings and relatives.
● Relatives said the service worked well with healthcare professionals but said the service's communication could sometimes be a barrier. Comments from relatives included, "I believe professionals have similar problems in getting in touch with Realise South West. Once in touch though they do respond" and, "The [service] seem to have good interaction with other healthcare professionals, especially when things were being set up initially. Everyone was involved in what [person] wants and needs. The [service] guided us through the transition from child to adult services. We feel so well supported by everyone."
● One healthcare professional said, "REALISE staff have worked hard to ensure MM's needs and outcomes are at centre of all care planning whilst trying to be sensitive to and balance MM's mum point of view and have always worked collaboratively with the health professionals and advocate to support her to recognise the benefit of following professional guidance and advice".

Continuous learning and improving care
● The provider looked for ways to improve care provision and learn when things went wrong.
● Incidents and accidents in the service were analysed and information about what they had learned was shared with other departments in the organisation.
● The registered manager was involved with a local focus group working to improve and promote health reviews for people with learning disabilities. As part of this work, the service was developing a document aimed at improving how information about a person's health and well-being was recorded. The same document would stay with the person and help professionals to identify, act on and monitor concerns.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open

and honest with people when something goes wrong

● The registered manager was aware of their responsibility in relation to the duty of candour. The registered manager said, "For me [the duty of candour] means that we are open when we make mistakes or get things wrong; we accept responsibility, we notify others of the mistakes or issues and work with them to put things right".