Somerset Care Limited

Inver House

Inspection report

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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

Overall summary

This inspection was unannounced and was carried out on 01 and 02 December 2015.

Inver House is a care home owned by Somerset Care Limited. It provides care for up to 53 older adults. The home has two sections, the main home and the Petals unit. The main home provides care for up to 37 older people, some of whom have physical disabilities and varying levels of mental frailty. The Petals unit provides care in a secure environment for up to 16 people who are living with a diagnosis of dementia. At the time of our inspection there were 40 people living in the home, 26 in the main home and 14 in Petals unit.

The home provides care over two floors. Petals unit is located on the ground floor and the main residential rooms are spread over the ground and first floor. Two lifts are available to assist people to access the upper floors.

Summary of findings

The home has several dining areas and lounges. The grounds are well-maintained and accessible to people living in the home. A hair salon and communal IT facilities are available for people to use if they wish.

The home 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.

After the comprehensive inspection in December 2014, we found the home had breached five regulations of the Health and Social Care Act 2008. We received action plans from the provider stating what they would do to meet the legal requirements in relation to improving their service. At this inspection we found improvements had been made to all the areas of concern.

People felt safe in the home, and expressed their satisfaction with the way they were cared for. Staff took care to ensure people were supported safely whilst moving around, and attended to people's needs promptly. Staff were trained to recognise the signs, and respond to allegations of abuse. Risks to people's health and wellbeing were known to staff and they took action to reduce these. Staff supported people in a safe manner, especially when equipment was required to enable them to move around the home safely.

Staff were subject to checks on their suitability before they were employed in the home. Staff and people had formed positive relationships and people said staff were kind and caring. A friendly and jovial atmosphere prevailed in the home and people appeared to be relaxed and calm. A range of activities was available and people joined in if they wanted to. Others preferred to observe or spend time in their rooms and staff respected this.

People consented before any care was provided and staff communicated with people when supporting them, ensuring they were comfortable and unhurried. Staff were fully aware of the principles of the Mental Capacity Act and applied these appropriately when caring for people.

People's medicines were managed safely and administered in a caring and discreet manner. Staff responded quickly and appropriately if a person became unwell. People were supported to access healthcare and appointments outside of the home.

There were sufficient staff deployed to ensure people's needs were met safely. Arrangements were in place to cover staff absences so that people received their care from staff that were familiar to them. Staff training was well-organised and effective and staff supervision was regular and purposeful. Staff felt supported and able to access support and guidance from their line managers and the registered manager.

People felt involved in decisions about their care and treatment. They gave regular feedback to the staff and the registered manager about their care and made suggestions for improvement. These were responded to positively and put in place where possible. People said they enjoyed the meals they were given and their feedback was sought regularly about the menus. People with specific dietary requirements were catered for. If people were at risk of dehydration or malnutrition action was taken to address this.

People were cared for as individuals and their preferences were recorded and respected. People's care and support plans reflected their current needs and were reviewed and updated regularly. Care records were written in a positive and respectful manner and staff reflected this in the way they cared for people. People said their privacy was respected and they were cared for in a dignified manner. Activities and trips to local places of interest were arranged. People could choose whether to engage in them or not.

The quality of the service provided was monitored through surveys, residents' meetings and reviews of care. Where improvement was identified the registered manager took prompt action. People knew how to complain and complaints were dealt with promptly. People said any concerns they had were discussed with them and a solution was found as soon as possible.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
This service was safe.

Good

Risks to people's health and wellbeing were assessed and managed appropriately. People received their medicines when they needed them and medicines were managed safely.

Staff had been trained in safeguarding adults. They were knowledgeable about the signs of abuse and how to respond to them.

People's needs were met by sufficient staff who were subject to checks as to their suitability before starting employment in the home.

Is the service effective?
This service was effective.

Good

Staff gained people's consent before providing care and applied the principles of the Mental Capacity Act when caring for people who lacked mental capacity to make some decisions for themselves. Staff received effective training and supervision and felt supported in the role.

People enjoyed the choice of meals provided and were supported to eat and drink sufficient amounts. If a person became unwell staff acted quickly to access medical help.

Is the service caring?
The service was caring.

Good

People and staff had developed positive, friendly relationships. They enjoyed a joke together and staff supported people in a kind and compassionate manner.

Staff asked people how they were feeling and addressed any concerns or requests in a calm and patient way.

People's privacy and dignity was respected. Staff spoke respectfully to people and discussed their needs in a confidential manner.

Is the service responsive?
This service was responsive.

Good

People's care plans were detailed and individual to the person. Staff cared for people according to their preferences and acted quickly when a person's needs changed.

Activities were planned around people's abilities and wishes. Trips to local places of interest or shopping were arranged.

People knew how to complain and complaints were investigated and responded to promptly.

Is the service well-led?
This service was well-led.

Good

The registered manager promoted a person-centred culture with openness and honesty at its heart.

Summary of findings

Support and advice was available to staff through a clear structure of supervision. The registered manager made themselves available to people and staff.

Action was taken to improve the service based on effective quality monitoring processes. Records were accurate, up to date and kept securely.

Inver House

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 01 and 02 December 2015 and was unannounced. The inspection team consisted of two inspectors and a specialist advisor in the care of older people and in particular those with cognitive impairment.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the service including the previous inspection report and notifications. A notification is information about, important events which the service is required to send us by law.

We spoke with 18 people living in the home and 2 relatives. We also spoke with the registered manager, deputy manager, 11 care staff, a chef and the activities co-ordinator. We observed staff providing care and support to people in the lounges, and during the lunchtime meal. We looked at care plans and associated records for 9 people, staff duty records, three recruitment files, records of complaints and accidents and incidents, medicine administration records, staff and residents' meeting minutes and the provider's policies, procedures and quality assurance records.

At the previous inspection in December 2014, we found five breaches of regulation. The provider had sent us an action plan detailing the action they would take to make improvements to the service.

Good

Is the service safe?

Our findings

At our last inspection in December 2014 we found the service was in breach of regulations relating to the safety of people. The provider had failed to ensure that care records and risk assessments were up to date and relevant to people's current needs. Arrangements were not always in place to ensure people received their medicines appropriately or were disposed of safely. The provider sent us an action plan which stated how they would address the concerns. At this inspection we found that improvements had been made as detailed by the provider in their action plan.

People said they felt safe and well-cared for at Inver House. One person said, "I feel very safe here. I can call on [staff] at any time if I was frightened or worried about anything at all".

Risks to people's health and wellbeing had been assessed and action for staff to take to help reduce the risk was documented. People's moving and handling needs were assessed and recorded. For example, one person's mobility care plan detailed the support they required to walk short and long distances. Staff knew people well and reminded people to use equipment to move around safely, if this was required. We observed all moving and handling manoeuvres were carried out in a safe manner. People had been made aware of the risks to their health and showed an understanding, for example, of why they required particular pieces of equipment. One person said, "I don't like using the stand-aid but I know I have to". A relative said their family member required the use of a hoist to enable them to get into their wheelchair, saying, "They always have two staff to do it; they have to do that for safety". Staff said they reported to the senior on shift when a person's mobility deteriorated. This led to the person's mobility being reassessed and increased support provided if necessary. This was then checked again to see whether the increased support was sufficient to reduce the risk to the person. Equipment, such as hoists, stand-aids and wheelchairs was checked and maintained appropriately.

Where a person's condition was deteriorating and risks to their health increased, this was noted in their care plan; risk assessments were updated and staff were informed of the change; further professional help was sought and their advice recorded and put into practice. If a person had a fall resulting in a possible head injury, staff monitored their condition at frequent intervals so that prompt action could be taken if they experienced any health complications.

Several people were at risk of pressure injury and required staff to support them to reposition every four hours. Charts were kept for staff to record the time they supported the person to turn and the position they were in at the time. On two people's charts we found several gaps of between 5 and 8 hours. Neither of the people had developed pressure injuries, however, we spoke with senior staff responsible for the charts. They said they would look into whether the repositioning was not happening or whether the record was not up to date.

Staff reminded people to use their call bell if they required support, and if they were not able to get to a call bell in a communal area, a pendant call bell was made available to them which could be worn around the neck and enabled people to summon staff assistance. We observed that calls bells were answered promptly and people said they had no complaints about the time taken for staff to attend to their needs when they used the call bell.

The provider had in place appropriate procedures for obtaining, recording, storing, administering and disposing of medicines. Medicines were administered in a safe and discreet manner. People's consent was obtained before they were given their medicines, which were administered at the time indicated on their medicines administration record (MAR). People said they were satisfied with the way their medicines were administered. They commented, "I am not on medicines as a rule; but if I do need pain relief I can always get it", "They handle medicines first class", and "I can get medication at any time; I just ask".

Medicines controlled by law were stored and administered in line with guidance and two staff always signed when these were given to people. Medicines prescribed on an 'as and when necessary' (PRN) basis were managed safely. Clear guidance was available for staff as to when the person should be offered the medicine. One person was prescribed a medicine to help reduce anxiety. When this was given to the person, staff recorded the reason why, the dose and the effect that the medicine produced. This enabled the registered manager to monitor the use of PRN medicines to ensure they were used correctly. A pain assessment tool was in use for people who were not able to verbally communicate the level of their pain.

Good

Is the service safe?

Medicines were stored securely. A lockable trolley was in use and this was kept locked whilst staff gave people their medicines. A lockable fridge was available for medicines that were required to be kept cool and a record was kept of daily checks on the temperature. Medicines no longer required were returned to the pharmacist. A record was kept, however this was not countersigned when the medicines were collected and taken off the premises. The guidance in use for the administration of medicines was dated 2013 and so would not reflect latest best practice. The deputy manager said they would look into sourcing a more up to date source of guidance.

There were sufficient numbers of well-trained staff to meet people's needs. Staff were clear that the level of staffing in the Petals unit should not go below three staff in order for people to be cared for safely. Staff from the main home covered breaks for staff in the Petals unit to maintain this level of staff. Staff said they felt there were enough staff on duty to enable them to carry out their duties without being unreasonably rushed. Staff said they had, "time to talk to people and make sure they were okay". The home employed four flexible staff who were able to cover staff absences. Staff rotas were prepared with a mix of staff skills and experience, and each member of staff on duty had clear delegated responsibilities in a specific part of the home. A regular visitor providing a service in the home said there were always staff on hand to support people. They commented that staff always ensured the person was safe and comfortable before leaving them.

Staff recruitment practices were safe. Staff applying to work in the home were subject to an interview which covered their skills, knowledge and suitability to work with people living in the home. Checks were made as to their medical fitness to work, conduct in previous employment and criminal record checks with the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

Staff took seriously their responsibility to safeguard people from harm. They had all been trained in safeguarding adults and could recognise the signs that a person may be experiencing some form of abuse. Staff were confident that the registered manager would take appropriate action if they had concerns about the wellbeing of a person in the home. They were also confident to report their concerns to the provider's operations manager should this be necessary. Staff referred to a safeguarding information poster which was posted in the home if they needed to contact the local authority in connection with abuse. In Petals unit, sometimes incidents occurred between two people that required staff to intervene to keep people safe. People's care plans contained guidance about how staff should act and staff were clear about what to do. They took action in a calm and kind manner and this usually resulted in the situation being diffused. Where harm was caused this was responded to appropriately and reported to the relevant local authority safeguarding team and to CQC.

Good

Is the service effective?

Our findings

At our last inspection in December 2014 we found the service was in breach of regulations relating to the effectiveness of the care people received. The provider had failed to put in place arrangements to ensure that people who lacked the capacity to make decisions were cared for appropriately and in their best interests. The provider sent us an action plan which stated they were addressing the concerns. At this inspection we found that improvements had been made as detailed by the provider in their action plan.

People said their care was delivered by well-trained staff and that their needs were met. They commented, "You can't beat [the staff]; they will do anything to please you", "The care is first class" and, "Staff get on with it; they are nice, not in your face". A relative told us, "They care for [my relative] very well here".

Staff were clear about how the principles of the Mental Capacity Act 2005 (MCA) applied to the way they cared for people. The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. Staff said they assumed people had the capacity to make their own decisions and were aware of the importance of ensuring people were supported to make choices and decisions for themselves. Where people lacked capacity, this had been assessed and decisions were made in their best interests by people who knew them well. This was documented and care plans had been produced to ensure they were cared for in the most effective manner. People's rights were protected because details were included about who had the legal right to make decisions on behalf of people and staff were aware of the arrangements in place.

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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found applications for DoLS had been made appropriately for people living in the home, and staff were aware of who was subject to a DoLS and why the DoLS was in place.

Staff ensured they gained consent from people before any care was provided to them. One person said, "They don't do anything in my room without asking me first". If a person was reluctant to receive personal care, staff were guided by people's care plans so they could still provide effective care whilst respecting people's rights. Staff acknowledged that the person may not want to be cared for by particular staff but were not able to express this clearly. The guidance included different staff offering to support the person or, two staff provided the support so that one staff member could distract the person while the other staff attended to their personal care. Staff said these approaches were usually effective.

Newly employed staff completed a comprehensive induction and support programme. This was in line with the Skills for Care common induction standards. This comprised training in using moving and handling equipment safely, providing care with dignity and respect, writing care plan entries and action in the event of a fire. Staff also completed 'shadow shifts' with experienced staff before being allowed to work unsupervised. A mentor was appointed to support the new staff through their induction period. Two staff were trained as mentors and five others were undergoing training to become mentors. This role involved providing support to new staff completing their induction and working alongside them. Mentors recorded their observations of new staff's care practice including their adherence to infection control procedures, answering call bells and delivering personal care. Staff then went on to complete the Care Certificate, which provides care staff with the skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

A programme of training and support was in place to ensure all staff had the skills they required to care for people effectively. The registered manager held an electronic record of the training staff had received. Training was categorised as core training; such as safeguarding, moving and handling and health and safety; and specific training, to meet people's individual needs such as dementia awareness. The monitoring system in place enabled the staff training needs to be easily identified and refresher training in equality and diversity, end of life care

and first aid was planned in the coming months. Staff were aware of the training they were required to complete and added their names to the list posted in the staff area. Staff said they benefitted from the training they completed. One staff member said of training they had completed in dementia awareness, "it was brilliant; it really helped you to understand why people say what they say", and they gave an example of how they had used this to enable them to understand a person they cared for in a more compassionate manner.

Staff received support through supervision and mentoring. Staff said this enabled them to get the support and learning they needed. Staff spoke positively about supervision sessions with senior staff. One member of staff said, "[At supervision] information is passed on to us, [as well as] thanks for hard work, upcoming training and just if there is anything you want to talk about really". Another commented, "I feel supported; I have access to the manager any time. If she's busy, she asks if it is urgent. If it is she'll see me straight away; if it isn't then we make an appointment". Staff said they felt they were moving forward in their career and constantly learned from each other. Staff were able to gain further qualifications and several staff said they had completed a vocational qualification whilst working in the home. Staff said they were supported to do this, saying, "It's been brilliant - the support here".

People enjoyed the food provided in the home. They commented, "The food is very good; I have cornflakes and toast and marmalade for breakfast; If I wanted something more I just have to ask", "You get choices for lunch and tea", and "Dinner is always tasty; you get enough but you can ask for more if you like". A relative said their family member didn't like fish adding, "[The staff] always offer her something else".

People had a choice of where they liked to eat their meal, with some people choosing the dining room areas and others preferring to eat their meal in their room. The atmosphere in the dining rooms was relaxed and chatty and the décor was warm and welcoming. Tables were set in restaurant style with flowers on the table, light music playing in the background and fresh fruit available. The chef came into the dining areas and talked to people about their meals. They asked people if they were happy with their meal and responded to their comments. The chef catered for five or six different diets including diabetic, pureed food, low salt and vegetarian diets. They prepared desserts with low sugar to make them more accessible to people with diabetes. One person required a soft diet but was reluctant to be treated differently from other people. They were not able to eat roast potatoes so the chef scooped out the inside of the roast potato and served that, so the person was able to have the taste of roast potato whilst still remaining safe when eating. Staff took care to explain to the person discreetly what they were having so they did not feel they were a 'special case'. The chef was conscious that large portions could be off-putting to people with a reduced appetite and adapted the portion sizes accordingly, making sure people knew they could have second helpings if they wanted.

People received support to eat their meal, such as having their food cut up, where this was needed. This was provided in a discreet manner after the person had agreed to the support. Some people had health conditions which caused them difficulties swallowing. A soft diet had been prescribed for them and we saw they received their meals in the appropriate way to reduce the risk of choking. Where people had been assessed as at risk of malnutrition or dehydration, their food and fluid intake was recorded and staff were aware of the target amount the person should be consuming and what to do if their intake was causing concern.

Staff checked that people enjoyed their meals, what people wanted and their choices. Staff were attentive to people's needs. For example, one person was heard to comment on the potatoes being tasty and the member of staff offered to go and find out what type they were. They did this promptly and there was further discussion about the meal. Staff spoke to people individually and checked if people had finished or if they would like more before they took their plate away.

A choice of drinks were available at mealtimes, throughout the home and in people's rooms. Relatives said their family members were encouraged to drink sufficient amounts to maintain their health and we observed staff offering drinks to people throughout the day. Where people were at risk of dehydration this was noted and staff were aware of who needed encouragement to drink more.

The home had menus in place that had been designed by the provider organisation. Whilst adhering to the nutritional value of the menus the chef made small adaptations to accommodate people's preferences. For example, the chef explained that people did not like gooseberry tart, but,

Good

Is the service effective?

"they do love a crumble", so they made gooseberry crumble as an alternative. The calorific value of every item on the menu was recorded and the chef discussed any changes to the corporate menu with the registered manager to ensure people received equivalent nutritional intake from the proposed changes. A 'caring menu' was in place which listed all the ingredients contained in the menus and what they contained, for example, items with nuts, milk, eggs or fish. This enabled the chef and kitchen staff to provide food choices to people that took account of any food allergies they may have.

People said they were able to access healthcare when this was needed. One person said if they needed to see a doctor, "This is arranged straight away". In addition, a GP visited weekly to see anyone that required health care support. A relative said, "They are very good at getting a doctor to see [my relative] and they let me know too". People's records of care showed visits with health and care professionals were arranged regularly; these included visits from opticians, hearing specialists, chiropody and district nurses where applicable. Where advice had been given by visiting health and social care professionals this was recorded and passed on to staff to ensure people were cared for appropriately.

Good

Is the service caring?

Our findings

People said staff were kind and caring. They commented, "If I wake up in the night, I just press my bell and they are here for me, all the time", "I sometimes get quite low; care staff really care. We have a chinwag and I feel better", "If I ever ask for anything it's done within minutes; [care staff] really go above and beyond; it's the best care I've ever received" and, "This home has the best atmosphere; there is a buzz of cheerfulness and the staff are the best". Regular visitors to the home said staff were, "always caring; that's never a problem", and "They [the staff] definitely have a caring manner".

Staff and the people they cared for had formed positive relationships. Staff greeted each person by name as they encountered them. When they were required to repeat something they had said they were patient with people and each time they repeated themselves it was as though it was the first time they had said it. One member of staff said they arrive at the home 15 minutes before their shift starts so they can, "go and see everyone and say hello, and check they are okay". Another member of staff said of people, "They are like family to me" and we observed staff cared for people with respect. People said they enjoyed living in the home saying they, "love it", "We all have a laugh here", "You can see we are quite happy here all together", and, "It didn't take long for me to settle; in every way I am relaxed". Staff and people enjoyed jokes together and a relaxed atmosphere was promoted by all staff.

Staff knew people well and used this knowledge to provide compassionate care. One person was observed in the hallway and appeared confused and asking about their lunch. Staff reassured the person that lunch was on its way, and asked them where they would like to eat. The person wanted to eat in their room so they were encouraged to make their way to their room whilst the staff member went to get the meal for them, saying, "By the time you get to your room I will be there with your lunch". The person agreed with this suggestion and proceeded to their room in a calmer disposition. People said that staffed, "checked on them", in a caring manner, ensuring they had the equipment they required, such as their walking stick. In the Petals unit, staff showed care and compassion for people and promoted a calm environment. Staff carried out their work in a way that focussed on people's needs rather than tasks. When people were being assisted to move, for example when using a hoist, staff were reassuring and kind. They communicated with the person throughout the manoeuvre, ensuring the person was comfortable and felt safe.

Throughout the day staff sought people's opinions and asked for their feedback. This was done informally and in a conversational manner. Staff listened carefully to what people said and responded positively to people. People could choose when they wanted support to bathe, and were offered choices throughout the day, including where they wanted to spend their time, what activity they wanted to engage in and where they wanted to eat their meal.

Staff knew people's background and history and used this knowledge to start conversations with people. The walls of the home were adorned with pictures and object of interest covering a wide range of interests to people such as photographs of the local area. This gave a homely feel; people stopped and observed these and they provided an opportunity for staff to engage people in conversation. Information about the home, changes, initiatives, photos of activities and trips, and people's birthdays in the past month was displayed in public areas. This was reproduced in large print to enable people to read it more easily, and copies were posted at eye level for a person using a wheelchair which meant they were able to access this information without asking for assistance. Also posted was information on advocacy services available to people in the home should they need them. These too were in large print.

People said they were cared for with their dignity in mind. People said, "They have a very private way of doing care", and, "We are always treated with respect; they cover me with a towel when I'm having a wash". Several staff were designated 'Dignity Champions'. This was a role that encouraged the care of people with their dignity in mind, and a wall display highlighted good and poor examples of respecting people's dignity. Staff spoke about people's needs confidentially, with respect and concern for their wellbeing and dignity.

People were able to spend time in their rooms when they wanted to, and there were several areas where people could sit quietly or receive visitors. One person said, "If I ring the bell and say I want to go to my room they always help me, and then bring me some tea". Staff showed that

Good

Is the service caring?

people's privacy was important to them and people who wished to remain in their rooms were checked on but left to their own peace and quiet where this was what people preferred.

Good

Is the service responsive?

Our findings

People said their needs were met and staff responded when their needs changed. One person said, "You just have to say, and they arrange what you want".

Staff knew people, and their individual needs well. For example, staff kept records of the fluid intake for people who were at risk of dehydration. People had different daily target amounts of fluid they should be encouraged to reach. Staff knew these and the reason why the target had been set at that level. Each member of staff had access to people's care records and contributed to these daily if they provided care to the person. People's care records were written in a personalised and detailed manner recording people's mood, activity, food and fluid intake, support to move and nightly checks. Some people required a low level of support for a particular activity and this was detailed in their care plan. For example, one person, initially, would not eat their meal without staff support, but once they had received a few mouthfuls they were able to take over and eat independently. This was recorded and staff provided the appropriate level of support to the person.

Staff cared for people as individuals and knew people's preferences. People's background and history was recorded and staff were familiar with these details about the people they cared for. Staff said, "The residents are so interesting", and, "They have such interesting stories they are so amazing". For example, one person said that in their former occupation they were required to dress smartly and they usually wore a suit. The day of our inspection was the person's birthday and the care staff that morning had asked, as it was their birthday, would they like to wear a suit today? The person was moved by this gesture and clearly felt proud to be well dressed on their birthday. They said, "The first thing [care staff] said to me this morning was, "Happy Birthday!" I was really touched by that". Another person preferred their soup to be served in a mug rather than a bowl, and would occasionally ask for their food to be cut up. This was recorded in their care plan and staff served the person their meals according to their preferences. People's preferred time to go to bed and get up was recorded in their care plan and records showed they were supported at these times.

Staff responded quickly to people's needs. One person pointed out to staff that whilst they liked the cardigan they were wearing, it did not have any buttons on it. The next day the person was seen wearing the same cardigan which now had four matching buttons on it. They said, "Look at this; yesterday I had no buttons. [Staff member] has sewn them on for me".

Action was taken to reduce risks to people. One person, whose mood and behaviour had been monitored due to concerns about their safety, was noted to have increased anxiety at a particular time of the day. The registered manager had put in place extra support for the person at that time, and staff were aware of the need to pay more than the usual attention to the person's whereabouts during this time. They knew what would indicate the person was feeling low in mood and took action to support the person appropriately.

Where people's care needs changed, staff were aware of this and how to care for the person in the most effective way. Staff attended handover meetings at the start of their shift during which all people living in the home were discussed. We observed a handover discussion. The supervisor checked with staff how long it had been since they were last on duty. Their answer determined how much detail they provided about each person, ensuring that staff were fully aware of people's current condition and needs. The handover covered people's health, appetite, activity and any concerns that staff may have about people's health or wellbeing. Staff were clear about the process to follow if a person's needs changed. One staff member said, "If someone is unwell, we inform the supervisor. They check and then contact the GP or [emergency medical help] if necessary. We record this on the person's [care records] and make sure it is handed over to staff on the next shift".

People said their care was discussed with them regularly and their family members were invited if they wished. When the review identified a change in their care need, action was taken to address this need. For example, one person's care review identified that they were at increased risk of pressure injury and required support to reposition when in bed. A turn chart was put in place and staff completed this record at the required intervals. Another person was identified as being at increased risk of falls. The frequency of staff checks was increased for the person and a record was made. Similarly, when a person became unwell and was on a new medication, staff were aware and made more frequent checks on them. This meant they could quickly identify if the person's condition was deteriorating.

Good

Is the service responsive?

People said they enjoyed the activities although some people felt that more could be made available to them. A range of activities were arranged and activities staff said this schedule was guided by people's abilities. On the day of our inspection people were decorating a Christmas tree and making Christmas wreaths. We later saw these were displayed on the door to each person's room. Activities staff took into account how people were feeling and said, "If things are not working out then we change tack and do something else". For people who were physically not able to join in the arranged activity, they were encouraged to observe. Staff said, "Come and sit with us, have a cup and tea". This, they said, helped people, "feel part of it" as much as they could. They adapted the activity to suit people's ability, using people's care plans and observations as a guide. They made the activity a little easier or harder for individuals as was appropriate. Activities staff spoke to people about their hopes, dreams and regrets and sought to engage with people, enabling them to engage in an activity they regretted not doing and were now not able to do unsupported. Trips were arranged for people that wished to visit local places of interest, or go shopping. One person said, "We went Christmas shopping; we spent two hours and stopped for a coffee as well; you can't beat it". Staff supported one person to enter a national craft competition in which they were runner-up.

The activities co-ordinator said that providing activities in the Petals unit was more challenging but still they were able to engage with people, saying, "to even get a smile or a giggle from them – it means the world to me". Where appropriate, activities staff provided one to one activities such as hand massage, or just chatting, but which focussed on the person as an individual. Activities such as quizzes, music, singing, and watching videos were included, and people were able to use electronic devices to access these if they wished to watch them alone. If a person wanted to go for a walk but the weather was inclement, staff accompanied them for a walk around the home to enable them to have a change of scenery and see different people. If the weather was good, they would take people with them when carrying out errands in the village which had the added benefit of helping the person feel they were being useful to staff. Carol singers and representatives of local churches visited the home and engaged with people, helping them to feel a part of the local community. One person told us they enjoyed arts and crafts. They had artwork equipment in their room and some they carried around with them. They spoke enthusiastically about this and were proud and relaxed when they were showing their paintings to us.

People had various ways to give feedback about their care. A 'You Said, We Did' system was in place in which people could make suggestions to improve their care and the provider responded. One suggestion was that a coffee morning was arranged with other residents of the village and this had taken place. People and their families were invited to monthly meetings and people's comments had been acted on. For example, people complained that germs were being spread by coughs and sneezes in the lounge. Tissues were now available in the lounges to remedy this. Another comment was that the activities schedule could not be seen very well. Details of all planned activities were now available to each person in their room. The registered manager had taken action to address other requests people had such as games like darts and board games. One person said, "You make a suggestion and they always think about it. They're fantastic!" A relative who attended the meetings regularly said, "They really are effective, especially now [the meetings] are monthly, rather than every three months".

People said their complaints and comments were taken seriously. They knew who to talk to if they had a complaint. One person said, "If I put a word in [to the staff] I'm pretty sure they'd do something about it". The registered manager kept clear records of complaints and these showed that complaints were investigated thoroughly. People were responded to verbally. The matter was then investigated and a written response was then provided to the person's satisfaction.

Good

Is the service well-led?

Our findings

At our last inspection in December 2014 we found the service was in breach of regulations relating to monitoring the quality of the service provided to people. The provider's quality assurance systems had failed to identify breaches of regulation, and some records were not up to date and accurate. The provider sent us an action plan which stated they were addressing the concerns. At this inspection we found that improvements had been made as detailed by the provider in their action plan.

People, and their relatives, said the service was well-led. People knew who the registered manager and the senior team were, and expressed that they were able to talk to them when they wanted. The registered manager promoted the philosophy of care in the home which was, "Everything based around our clients; safe and comfortable care with their care needs met". Staff echoed this philosophy in the way they delivered care.

The quality of the care and treatment provided at Inver House was monitored through regular audits and quality checks. The registered manager said they, "walk the home" every day. Talking to every person and each member of staff. They said, "This means they all know I am here, and they get a chance to tell me about any concerns". Regular checks were made on equipment used in the home and these were recorded along with remedial action required and taken. The deputy manager, who was trained to deliver moving and handling training, checked staff practice daily and addressed any concerns they had with refresher training for staff. Audits of medicines management were carried out regularly. These covered the ordering, recording, storage and disposal of medicines. In addition a check on medicines administrations was made daily by supervisors. Audits and checks were recorded which showed issues requiring attention were dealt with promptly.

People, and their relatives, said they completed a questionnaire regularly, which covered all aspects of their care and the way the home was run. The results from the latest survey showed that the vast majority of those who responded would recommend Somerset Care as a provider of care. People commented, "The care is perfectly fine", "I don't ask for much but the care staff go above and beyond", and, "The very best care I have ever received". Where people had commented on improvements that could be made, the registered manager had taken action to address these where possible. For example, a relative commented that the residents' meetings were not regular enough. These had now been made monthly rather than quarterly. Another person said that they wanted more activities at the weekends and that more domestic staff were required at the weekends. The provider had approved the recruitment of two new members of staff to meet these needs. A questionnaire was also sent to health professionals who regularly visited the home such as GPs and district nurses. Feedback from them showed they would like to see more continuity of staff to accompany them when they visited people in the home. The registered manager, or their deputy now made themselves available to do this.

Records were kept in a secure location. Paper records were kept in locked cabinets and computerised records required a password for access. Records were completed in full, were up to date and accurate.

The registered manager analysed records of accidents and incidents in order to identify any pattern that could be acted on to prevent further incident. One person, who liked to make their own bed, had an accident in which they banged their head on their bathroom door handle. Staff now reminded the person to close their bathroom door before making their bed in order to prevent this from happening again. When an accident occurred in the lounge area this was addressed at the residents' meeting reminding people of how to prevent this happening again. Incidents that were required to be reported to CQC were done so in a timely fashion and the registered manager responded quickly to requests for information from CQC.

Staff said they were supported by the registered manager and other senior staff. Staff had access to the registered manager and supervisors, and were clear about who they could express their concerns to, or seek advice from. Staff expressed confidence in the registered manager, and their deputy. One member of staff said they had, "great faith" in the registered manager and that they had, "changed the atmosphere of the home". Staff said that shift leaders handled queries and, "dealt with issues that arise from day to day", adding that shifts, "usually run smoothly". Outside of office hours an on-call system was in place so the registered manager and their deputy could be contacted. The provider had a free counselling service in place to support staff. This was a service that staff could access 24

Good

Is the service well-led?

hours a day. They also ran a 'Be Healthy' campaign with support and advice on health related topics. Staff also signed up to participate in team building activity, such as theatrical productions.

Staff supervision records were reviewed by the registered manager. They said this enabled them to monitor staff concerns and provide support and advice to the staff member's line manager if this was necessary. The registered manager endeavoured to promote staff from within the home and arranged support for them with their extra responsibilities. A member of staff said they had been given, "very good support" from the management team despite them being very busy, adding that they were, "given time to become confident" in their role. Staff said they were thanked for their continuing hard work in the home and felt confident that they would be supported to gain extra training or guidance if this was needed.

The registered manager said they, "Promote an open and honest culture" in the home. Because of this, staff felt able to admit mistakes, report poor practice, or seek support from senior management staff. Staff were aware of their 'duty of candour' responsibility. 'Duty of candour' is the requirement that providers are open and transparent with people who use services and other people acting lawfully on their behalf in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. One staff member said, "If I didn't admit what I'd done wrong I wouldn't feel right inside". The registered manager said their philosophy with staff was to, "Listen, not just act". This meant they would seek information and consult with others, "to ensure I know what is correct", before feeding back to staff. They then used monthly meetings with care supervisors to cascade information to the care team. Staff said they received feedback on their performance, stating that this was, "honest".

Staff meetings were held regularly, the most recent in October 2015. This was used as an opportunity to welcome and introduce new staff, address training needs and update staff on people's care needs. An issue in relation to lack of communication amongst staff had been identified. This was addressed by the registered manager implementing a 10:15am meeting of staff on shift each morning in addition to the handover meeting each at the start of each shift. This enabled staff to be clear about people's care needs and whether they had been met.

Residents' meetings were arranged monthly, and the dates for the year were sent to people and their relatives so they could plan to attend if they wished. Staff attended resident's meetings, and the chef told us they attended regularly. This, they said, was to gain feedback from people about the meals and respond to people's suggestions about new items on the menu. They also spoke to people on a daily basis to check they were happy with their meals. They said, "I tell people, "I am here for you; I want to cook what you like and not what I think you like"".