Somerset Care Limited

Somerset Care Realise (South West)

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

Summary of findings

Overall summary

This inspection took place on 12 September 2017 and was announced. We gave the service a short period of notice that we would be attending as we needed to ensure that senior personnel would be available during the inspection. This was the service's first inspection since newly registering with us in February 2016.

At the time of this inspection the service supported 25 people living in different premises, including single occupancy properties and shared occupancy accommodation. The service is registered for the provision of personal care in people's own homes. This includes support with personal care, such as assistance with bathing, dressing, eating and medicines. We call this type of service a 'supported living' service.

People's accommodation was provided by separate landlords, usually on a rental or lease arrangement. Somerset Care Realise was responsible solely for the provision of personal care and not for the provision or maintenance of the premises. People who used the service had a wide range of cognitive impairment and/or other support needs, ranging from mild to severe learning disabilities, autistic spectrum disorders and early onset dementia. People were aged between 19 and 70 years of age. Some of the people had very complex support needs and required a large support package from the service, and other people were more independent and received support for just a few hours a day to help with their daily routines.

People told us they felt safe. People's risk had been assessed and recorded, and risk management guidance for staff was available when needed. People's risks were assessed for when at home and when accessing the wider community. Where people had specific medical risks, guidance was available for staff to refer to during any emergency.

There were safe recruitment procedures undertaken. The service had staff vacancies but there were systems in place to ensure people's needs were met. There were systems to monitor reported incidents and accidents and people's medicines were managed safely and in line with their assessed needs.

People received effective care from staff that had received training to meet their needs. Where the need was identified, additional training specific to the needs of a person was provided. Staff were also supported through a regular supervision process to discuss their performance. Annual appraisals ensured development goals and objectives were set. New staff received and induction.

Where required, people received support to eat and drink and identified nutritional risks were managed. People had support to access healthcare professionals and staff were trained in the principles and application of the Mental Capacity Act 2005.

Staff were caring and people received care in line with their needs. During our conversations with staff, it was evident they knew people well and understood them. Staff commented on how they tried to encourage and promote people's independence. Staff understood people's medical needs and how certain conditions were managed. We observed positive interactions between people and staff during our visits to people's

houses. The service had received compliments about their care provision. People were involved in care planning and received key information about the service and its aims.

The service was responsive. People felt they received a responsive service and we observed interactions to support this. People received an assessment prior to care being provided to ensure the service could meet their needs. People's care plans were personalised, containing key information on how to support and communicate with them. There were systems in place to review care records. People were given information on how to complain. Surveys were sent to people in order to capture their views, and a new 'customer forum' was about to be launched to involve people in policy, care provision and quality assurance.

The service had adequate governance systems to monitor the health, safety and welfare or people using the service. The quality of service provision was also monitored. Staff spoke positively about their employment and the team ethos. There were systems to communicate key messages to staff. The service received provider level support through the operations manager in relation to quality auditing and business management. There were systems to communicate with people using the service through newsletters. The provider had employee incentive schemes to encourage good practice. The service submitted legally required notifications to the Care Quality Commission and the Provider Information Return requested from the service was submitted within the allocated timeframe.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People at the service felt safe.

Safeguarding and whistleblowing training was provided to staff.

People's risks were assessed and risk management guidance produced.

Recruitment was safe and there were sufficient staff to meet people's needs.

People's medicines were managed safely in line with their needs.

Is the service effective?

Good

The service was effective.

People received effective care from trained staff.

There was an induction programme with ongoing supervision and appraisal.

People's nutrition and hydration needs were met and managed.

People received support to access and attend healthcare appointments.

Staff received training in the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People said that staff were caring and supported them well.

Staff understood the needs of people they supported.

People were involved in the personalisation of their care plans.

The service had received compliments from relatives and

professionals.

People were given key information about the service.

Is the service responsive?

Good

The service was responsive.

Staff were responsive to the people they supported.

People were able to complain and complaints were responded to.

People's needs were assessed prior to the delivery of care.

Care records were personalised and unique to the people they related to.

The service sought the views of the people it supported.

Is the service well-led?

Good

The service was well-led.

Staff spoke positively of their employment.

There were quality assurance systems and care practice was observed.

There were systems to communicate with people and staff.

There were employee incentive schemes.

Notifications and the Provider Information Return were sent as required.

Somerset Care Realise (South West)

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 12 September 2017 and was announced. This inspection was carried out by two adult social care inspectors. This was the services first inspection since newly registering with us in February 2016.

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 any improvements they planned to make.

We reviewed the information in the PIR and additional information that we had about the service including statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

During the inspection we spoke with 10 people within their own homes and eight members of staff. This included an operations manager, the registered manager and care and support staff. We also reviewed five people's care and support records.

We looked at records relating to the management of the service such as the staffing rota, policies, incident and accident records, recruitment and training records, meeting minutes and governance systems.

Good

Is the service safe?

Our findings

People we spoke with felt safe and were satisfied with the support they received. People were comfortable with the staff that supported them. One person we spoke with said it, "Always feels safe here." They told us they liked living where they did. Another person said if they had any concerns they would talk with a team leader and said they could contact staff at any time. They told us team leaders visited them to ensure they were ok. A staff member told us the service aimed to make people as independent as possible and to help them cope with everyday life.

People's risk were assessed, and where necessary a risk management plan had been created to reduce any identified risks to keep people safe and reduce the risk of harm. Within people's records we found risk assessments had been completed for a wide range of risks both within people's homes and whilst they accessed the wider community. For example, people had risk assessments for the correct use of any specialist bathing equipment they used or when they used a razor themselves during personal care. Additional risk assessments were completed for the risks of people travelling in vehicles or undertaking social activities such as swimming or using adapted bicycles. We did highlight one example of a formal risk assessment not being completed in line with guidance from a Speech and Language Therapist (SALT). The registered manager rectified this immediately.

Additional risk assessments and risk management guidance was completed for people's unique medical conditions or behaviours where applicable. For example, where people may present behaviours that may challenge in the community, there was relevant guidance. For one person living with diabetes, we found that although the person self-managed their insulin and blood sugar level readings, there was guidance for staff in the symptoms to monitor and actions to take should there be a diabetic emergency. One person suffered from epilepsy. Within their file we found the service had obtained signed and recorded risk management guidance from an epilepsy nurse. This detailed guidance on how to use the required rescue medication if needed and emergency actions to be taken. Where required, relevant staff had received training in the safe use of medicines associated with the person's condition.

Safe recruitment processes were completed. Staff had completed an application form prior to their employment and provided information about their employment history. Previous employment or character references had been obtained by the service together with proof of the person's identity for an enhanced Disclosure and Barring Service [DBS] check to be completed. This DBS check ensures that people barred from working with certain groups such as vulnerable adults are identified. When a staff members DBS contained a disclosure, we saw the service had undertaken a risk assessment and followed the provider's policies based on the information received. We identified an administrative error in relation to the accurate processing of one DBS certificate using the 'DBS Update Service.' The check was correctly processed prior to our inspection concluding and we saw supporting evidence of this.

There were systems to protect people's finances. We reviewed a sample of some people's current and historical financial records. The service had systems that ensured people's money was safeguarded by competing frequent balance checks. In addition to this, additional checks were completed by senior

management periodically. We saw people's financial sheets were kept current, with a running balance of money coming in and out to ensure any issues would be identified easily. People also received support from staff. For example, in one person's house they had a money tin with their current records. The staff supported this person to budget. The person told us they managed their own money.

The service had a system that monitored incidents, accidents or events. This ensured that appropriate action could be taken to reduce the risk of repetition and that other relevant external agencies were involved where required. The relevant records we reviewed showed that incidents the service deemed critical were recorded and a record was maintained. This record detailed the incident, if the local authority safeguarding team were aware and the legal notification had been sent to the Care Quality Commission if required. It also detailed if an investigation had commenced and the outcome. A second folder contained information of less serious matters but ensured a record was maintained to establish patterns or trends.

The risks of harm to people were minimised because staff received training about how to recognise and report concerns. There were appropriate policies in place for the safeguarding of vulnerable adults and whistleblowing. We also saw the local authority multi agency policy was also available for staff. These policies contained information on the action to be taken in the event of a concern and how to report concerns internally and externally. People we spoke with felt safe and told us they could raise concerns. Within people's service user guide there was a safeguarding guide in an 'easy read' format explaining what safeguarding meant, who people could complain to and what action would be taken.

There were sufficient numbers of staff to support people safely. Staffing levels were deployed based on people's funded hours. The service currently had a number of vacancies. The current staffing shortages were being managed by additional staff and with agency staff. The registered manager told us that they had an agreement in place with a local agency to 'block book' certain agency staff for a fixed period of time to help provide continuity in people's care. This was confirmed by staff we spoke with. The registered manager also explained there was a recruitment campaign in the local area to encourage recruitment. In addition to this, care packages were only being taken in the event a stable and dependable staff team were in place. On the day of our inspection, four new members of staff were currently undertaking their second week of induction training and would shortly begin providing care to people.

Medicines were managed safely and in line with people's assessed needs. The support people received from staff at the service varied. For example, some people managed their own medicines with no support from staff and others required staff to support or prompt them. Appropriate assessments had been completed for people. We saw that risk assessments had been completed where medicines were required to be taken into the community in the event of an emergency. People told us they received the support they needed with medication and within people's houses we saw that medicines were appropriately secured and records had been completed correctly. Staff received training in medicines management and their competency was assessed. There were governance systems to audit medication practice. Where errors were identified, this was addressed with staff through reflective practice and supervision.

Good

Is the service effective?

Our findings

People received effective care that met their needs. We observed examples of how effective care provision had impacted positively on people. People we spoke with also gave us examples of how their lives had improved. One person explained how they had previously mobilised in a unique fashion but since receiving care from the service had started to use a walking aid. Another person when asked said they were, "Happy here." They then said, "Staff area a very dedicated team."

Staff were supported through a regular training programme. We reviewed the training records held within the registered office. These showed that staff received training in key areas regularly. This supported staff in providing effective care to people that met their needs. Staff we spoke with were very positive about the training package they received, and commented the training was specific to the needs and conditions of the people they supported. One staff member described the training as "Brilliant." Training in core subjects such as moving and handling, medication, health and safety and safeguarding was completed. The service had the benefit of an onsite trainer in the registered office who also held the required accreditation to provide moving and handling training.

Training was also provided to staff in additional areas to meet the specific needs of the people they supported. For example, some staff had received training in diabetes to ensure they had the required knowledge to help support someone safely. A staff member we spoke with told us how this training was put into practice. Some staff received training in epilepsy, including how to use the prescribed rescue medication should it be required. Additionally, some staff were being trained in advanced Makaton (using signs and symbols to communicate with people who did not communicate verbally) to help improve communication with some people. Training in how to manage behaviour that may challenge was provided where needed.

The provider ensured that staff received regular supervision and appraisal to monitor care delivery and to enable staff to progress and develop. Staff supervision was scheduled to be completed every six weeks. Staff we spoke with felt supported and told us they received their supervision and appraisal. This was supported by the records we reviewed. The registered manager kept a record of when supervisions and appraisals had been completed or when they were due. Records showed that during supervision a general review was discussed, including what had gone well and where improvements could be made. Also discussed was the effectiveness of the staff member and their relationships with people and colleagues. Annual appraisals focused on staff competencies, their development and annual objectives.

The provider had a two week induction process for new staff which, where required, encompassed the new Care Certificate. This was introduced in April 2015 and is an identified set of standards that health and social care workers should adhere to when performing their roles and supporting people. The Care Certificate is a modular induction and training process designed to ensure staff are suitably trained to provide a high standard of care and support. New staff were further supported with shadowing senior staff, progressive supervisions, observations and key training through the initial stages of their employment. We reviewed the records of a Care Certificate currently being completed.

People were supported to have access to healthcare professionals where required. We saw within people's care records that where required staff had supported people to arrange or attend appointments with healthcare professionals. For example, the service were in contact with a diabetes nurse where required and an epilepsy nurse had been involved in the support plan and risk guidance for a person. Some 'Health Action Plans' we reviewed showed where the service had requested the support of a GP, physiotherapist, a chiropodist or psychiatrist. This evidenced that referrals or support to meet people's on-going health needs were made.

People received the required level of support in relation to ensuring they ate the right meals and had sufficient amounts to drink. The registered manager told us there was no person currently receiving care that was suffering from malnutrition. The service were supporting some people with weight management in relation to supporting them make healthier food choices, whilst respecting the person's right to make independent choices in relation to their meals. Where possible, people were supported by staff to be as independent as possible in the preparation and consumption of food. People's care records contained a nutritional assessment showing the level of support required and personalised choices.

Where people were at risk during meals of choking or had swallowing difficulties, this was managed through documented guidance for staff and relevant risk management records. Where required, professional guidance from a Speech and Language Therapist (SALT) had been incorporated into a person's care plan. For example, guidance on the correct positioning, environment, food type, adaptive equipment and assistance level required was recorded. Instructions and guidance on food thickening was also recorded. Where a person was at high risk due to swallowing difficulties, a specific risk care plan designed by the National Patient Safety Agency (NPSA) was within the person's care records to reduce the associated risks.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 a person lacks the mental capacity to make a particular decision, any made on their behalf must be in their best interests and the least restrictive option available. Some people supported by the service had capacity to make decisions and care records reflected this. Staff had received training in the MCA to ensure they understood their role when people did not have the capacity to consent to certain aspects of their care.

Staff were issued with a pocket guide in order to prompt and encourage them to act in accordance with the principles of the Act. We found examples of where people's capacity had been considered when a decision was being made about a specific matter. For example, we found an example of where a capacity assessment had been completed for a person going on holiday. An additional assessment was seen relating to a person's ability to manage their own finances. We saw the person was involved in this best interest decision and the service had given the person coins and products to help them try and demonstrate they understood the concept and value of money.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for people living in supported living situations or in their own homes can only be authorised through the Court of Protection (CoP). These applications are completed and submitted to the court by the local authority, however there is an expectation a domiciliary care provider liaises with the relevant local authority when required to highlight where a deprivation of liberty may be occurring. The registered manager showed us evidence of communication with the local authority where they had raised concerns about people's liberty being deprived. The service was currently awaiting communication from the local authority.

Good

Is the service caring?

Our findings

People were relaxed in the company of staff and it was apparent there were good relationships formed. One person we spoke with said, "Staff are always kind and polite." Another comment we received was someone telling us the service was, "The best company I have ever been with." Another person we spoke with said, "Staff are polite and respectful." Another comment was a person informing us they felt staff were very kind and said they were always polite and treated them very well.

Staff we spoke with understood people's care and support needs and demonstrated they knew how people preferred to be cared for. Staff had a detailed awareness of people's needs and demonstrated they clearly knew people well. They understood people's likes and dislikes, their social preferences and personal care needs. This demonstrated that staff aimed to deliver care in a person centred way and treated people as individuals. One staff member explained their approach. They understood people have their own way of doing things and said as staff they had to change to understand how people want to be and respect their choice. They said people should live as they please but they did try and, "Point them in right direction."

We spoke with a member of staff about the management of a person's diabetes. The staff member had a detailed knowledge of how to care for the person. They told us the person was independent in their diabetes management but they monitored blood sugars. They knew the person's normal safe blood sugar range and told us at times it could go high. They explained where necessary foods were stored in the event of low blood sugar levels and that they knew what foods worked for the person. They explained the person saw the diabetes nurse and went to hospital when needed. This demonstrated the person's independence and decisions were respected but staff understood the person and their condition should they require support.

We saw positive interactions between people and staff when we visited their homes. People were comfortable with the staff that supported them and it was evident that strong, positive relationships had been formed. During a visit to one person's home we observed a very positive interaction between a person and staff. One person was discussing a current health concern with staff and the staff member suggested possible courses of action the person could take. This led to the person calling their GP for support. The staff member also discussed other options such as the different medicines they could take and also discussed the strength of medicines available and possible outcomes with the person if they took different medicines. The person opted for a pain relieving medicine and then discussed their concerns with their GP.

People were involved in their care planning. People's care records evidenced how people wished to be supported and showed this had been discussed with them. There was personalised information within people's records such as how people wished for their personal care to given. We also saw that where people had a specific interest or like, where possible the service had tried to make the care plan more person centred. For example, one person supported a specific football club and images of this had been imposed onto the paper used to create the care plan. Another person was passionate about superheroes so different characters had been imposed onto the paper used to record the person's assessed care needs. This helped encourage the person to take interest in their care plan.

The provider maintained a log of compliments received from people, their relatives and other healthcare professionals. The compliments reflected the positive feedback we had received from people and the observations we made during the inspection. One compliment card which was received from a family friend read, "I would like to express sincere thanks to one of you carers [staff member name]. He is an outstanding carer and delivers an excellent service." Another compliment was via the telephone from a person's mother highlighting the service had, "Made amazing achievements with their daughter."

A further compliment we reviewed came from a social worker assigned to a person who now received care from the service. The compliment reflected the support given by the service and read, "Thank you for all of your support with [person's name] and for me as well as his social worker. Having your team behind me and your understanding when I have been overwhelmed by the situation for [person's name] has been so incredibly helpful."

People were given information about the service. People were given a 'service user guide' when they commenced a care package. The guide contained information about the service, for example there was information on who the registered manager was, the address of the office and important contact numbers. People were also told the aims of the service, how the service aimed to help people realise their dreams and improve their life skills. There was information about what the service did, the role of the support worker and how plans were reviewed.

Good

Is the service responsive?

Our findings

People were positive about the responsiveness of staff when we spoke with them. People gave us examples of how staff continued to support them in the community. For example, one person we spoke with told us they did not like being supported by agency staff. They went on to tell us the service had ensured they made appropriate changes that meant the person was only supported by staff of their choice. Another person told us they, "Can go where he chooses." Another person had their support hours adjusted to ensure staff could take them into Bristol for evenings out. A person who had commenced care with the service told us since being with the service they were, "Much happier now."

People told us they would be confident speaking with staff if they had any concerns or complaints. People received a complaints guide in an 'easy read' format to support them to understand it. This gave guidance on how to make a complaint, what the service did about complaints and what happened after the complaint was made. The service had received eight complaints in 2017 of varied nature. The complaints log showed how these had been responded to and if the matter had been escalated with a third party agency if the need was required.

We found people's needs were assessed prior to them receiving care from the service. A comprehensive assessment was completed to ensure the service could meet people's needs. The initial assessment was personalised, detailing people's circle of support, their health and emotional needs, nutrition requirements, their communication abilities, how to keep the person safe, the preferred gender of their care staff and their decision making ability. Following this assessment, the service would establish if they could meet the person's needs. If the service could, a personalised care plan would be completed.

Personalised care records contained information unique to the people to whom they related. This showed that care records had been completed in conjunction with the people whose needs they were designed to reflect or their representatives. Records contained detailed information about the level of support people needed. For example, there was guidance for people on how they wished their personal care to be delivered, how people communicated, their mobility and how they wanted support emotionally and with personal relationships. The guidance we reviewed was detailed. For example, in one record with a personal care section it read, "When having a bath I only use a small amount of bubble bath as if I use too much this can make my skin irritable and itch."

Care records also had sections entitled 'Top Tips to Support Me' and a 'One Page Profile.' This profile quickly identified to staff what people liked and admired about the person, and information such as what was important to them. The 'Top Tips to Support Me' section gave staff a quick guide at what was important to the person at that time and key matters to take into consideration during support. For example one record read, "Help me settle into my new home. Reassure me that you are there to help. Communicate clearly and effectively and interact with me when at home." This supported staff in giving a personalised service.

The service understood the importance of ensuring effective communication was made. All of the people at the service had either personally completed or been supported by staff to complete a communication

survey. This asked people how they would prefer to be communicated with, how they would prefer to receive shared information, if they understood the communication they received from the GP and if staff included them in a way they liked. In addition to this, we saw that a detailed communication passport was created within people's care records to support staff in communicating with people in an appropriate manner.

Where people did not communicate verbally, it was evident the service had worked in conjunction with the person, their family or representatives and relevant healthcare professionals. Within one person's record, there was personalised information about the signs or gestures they used to communicate their feelings or needs. For example, it recorded that if the person wanted to talk or spend time with you, they would take your hand and lead you to where they wanted you to go. Another person's records showed different ways they communicated if they were happy, upset, hungry, unwell or in pain. This demonstrated a personalised approach to communication and understanding people's needs.

There was a system that ensured people's care needs and records were regularly reviewed. Staff would complete a monthly review with people. This encompassed an overview of the person's current health, if they had any outcomes they wished to achieve in the following month and any further or ongoing outcomes the person may want or have. The reviews ensured people's medical needs were met, and that any medical appointments were recorded and any outcomes or guidance given following the appointments were recorded. This showed the service had systems to continually ensure they delivered personalised care.

An annual survey had been sent out to all people using the service around April and May 2017. People and their relatives were asked for their views on different aspects of the service. For example, questions included if people felt safe, if they thought care was effective, if staff were caring and if the service was responsive and well led. We reviewed the 12 completed surveys given to us that showed positive results. With most people rating the service they received as either good or outstanding and also recording that they would recommend the service to others.

The service was also due to launch a new scheme in October 2017 that would ensure people's voices were heard. A 'Customer Forum' was being launched and was an opportunity for people to have their say in how the service was run. The registered manager told us this would give people the opportunity to be involved in policy, care delivery and quality assurance systems. The service had arranged transport and a location for the first meeting in October. We saw the agenda items to be discussed were what to call the forum, to vote in a chairperson, to choose what people wanted to discuss and when the next meeting would be. This was hoped to be a success and people were encouraged to participate.

Good

Is the service well-led?

Our findings

Staff spoke positively of their employment. During our conversations with staff no concerns were raised about the level of support they received or their employment satisfaction. One member of staff we spoke with told us, "Senior staff are very supportive." When asked about teamwork and team cohesion no concerns were raised. One member of staff we spoke with was positive about the team they worked with and commented, "Staff pull together to help each other - good team work."

The management communicated with staff about the service. Periodic senior team meetings were held that discussed matters such as service compliance, Care Quality Commission requirements, record keeping, recruitment and complaints. In addition to this, staff meetings were held approximately every two to three months and staff we spoke with confirmed they attended. We reviewed the supporting minutes of meetings held in May and July 2017. These showed that matters such as behaviour towards colleagues, medicines, support plans, dress codes, activities and professional boundaries were discussed. Staff told us they were encouraged to contribute and give opinions.

There were alternative systems that communicated information about the service to people. A newsletter had been produced in August 2016. The newsletter was named, 'The Individual' and was distributed to people using the service. The newsletter detailed material such as a celebration of people's personal achievements, any upcoming events or birthdays, staff fundraising events and fundraising events that people using the service had been involved in. The registered manager told us they hoped to recommence the newsletter shortly and increase the publication frequency to quarterly. Another newsletter was produced for people living in a supported living block of flats where nearly half of the service's clients lived. This communicated events unique to the accommodation and had been done by a person using the service with the support of staff.

There were management governance systems that monitored the quality of care provision at the service. Senior staff completed 'spot checks' in the community and observed staff practice during care appointments. These were aimed to be completed at the frequency of a minimum of one observation per month per staff member. They also ensured that in addition to the observation, people and staff had a chance to feedback to the observer and the findings were discussed with staff. Any shortfalls identified were communicated to staff if required. This ensured that issues were highlighted quickly to staff to reduce or prevent the risk of reoccurrence.

There were a range of auditing systems in operation. For example, audits were undertaken in relation to complaints and compliments received. There was a system to review reported incidents and accidents and supporting records. There were systems that ensured support plans and supporting records were audited for quality and accuracy. These had been effective as they had identified some records required additional information. Staff files were checked to ensure they contained the correct information. Senior staff also held themed conversations with people and staff based on key questions asked in the inspections by the Care Quality Commission. The results of these were also audited.

The service also received provider level support in relation to governance and quality monitoring. The operations manager completed an independent monthly audit that focused on areas including the delivery of personalised care, staffing and recruitment, increase of business and finance and promoting business activity. Following all of the auditing completed, a continual service improvement action plan showed individual matters that required addressing. This showed the service aimed to continually develop and improve the quality of service provided.

There were incentive scheme for employees to drive improvement and promote a high standard of care provision. The provider, Somerset Care, held annual awards for staff achievement and recognition. Staff could be nominated for outstanding practice from various sources. This included fellow employees, people using the services, their relatives or healthcare professionals. A selection of the categories at the awards included 'Outstanding care worker', 'Best newcomer', 'Manager of the Year', 'Inspirational trainer' and 'Team of the year'. Staff from the service had previously been nominated and won at these awards. In addition to this, the registered manager held a monthly staff recognition award where staff could receive a certificate and small gift if the winner.

The registered manager was aware of their obligations in relation to the notifications they needed to send to the Commission by law. Information we held about the service demonstrated that notifications had been sent when required. The Provider Information Return (PIR) we requested was completed by the registered manager and the PIR was returned within the specified timeframe.