Somerset Care Limited

Somerset Care Community (South Somerset)

Inspection report

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10 January 2018

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was announced and took place on 13, 14 and 15 December 2017 and 10 January 2018.

This service is a domiciliary care agency. It provides personal care including nursing to 177 people living in their own houses and flats in the community. It provides a service to older adults, younger disabled adults and children.

Not everyone using Somerset Care Community (South Somerset) receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

At the time of the inspection there was a manager in post applying to be the 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. They were supported by a care manager to run the service and the operations manager. On the first day of inspection a registered manager from another of the provider's services came to support the manager.

Some people with specific health conditions did not have enough guidance for staff to follow to ensure their needs were met consistently. People's medicine was usually administered safely and in line with their needs. Improvements were required with the medicine administration records. Most accidents and incidents had lessons learnt identified and action taken. Sometimes these actions had not been recorded fully.

Risk assessments were carried out to enable people to retain their independence and receive care with minimum risk to themselves or others. People were protected from potential abuse because staff were able to recognise signs and knew how to report it. People had a mixed opinion about whether there were enough staff; the management were taking actions to improve this. Some people did not feel their call times considered their medication needs which the management were going to review.

The provider and manager wanted to provide high quality care for people. People had mixed opinions about the management because they felt changes had not been communicated to them. There was a positive approach to improving the service. Staff felt supported and the new manager and provider had brought about positive improvements. The management had systems to monitor the quality of the service and made improvements in accordance with people's changing needs. They had completed statutory notifications in line with legislation to inform external agencies of significant events.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible. When people lacked capacity actions to ensure the statutory principles of the

Mental Capacity Act 2005 had not always been recorded. People and their relatives were positive about the food and meals were prepared to meet people's needs and wishes.

Staff had the skills and knowledge required to effectively support people. People and their relatives told us their healthcare needs were met and staff supported them to see other health and social care professionals. Staff were proactive in identifying when people's health started to decline.

People and their relatives told us, and we observed that staff were kind and patient. People's privacy and dignity was respected by staff and their religious needs were valued. When people had specific needs or differences they had been considered by staff. People, or their representatives, were involved in decisions about the care and support they received.

Most care and support was personalised to each person which ensured they were able to make choices about their care. People and their relatives knew how to complain. There was a complaints policy and complaints had been managed. There were occasions the outcomes had not been communicated with the relevant people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People with specific health conditions did not always have guidance in place for staff to follow.

People had mixed views about whether there were enough staff, which the management was taking action about.

People could expect to receive their medicines as they had been prescribed but there were times when visits did not consider people's pain management. Some improvements were required for people's medicine administration records.

Accidents and incidents had lessons learnt. Improvements were needed for the recording of the actions taken.

People had risks of potential abuse or harm minimised because staff understood the correct processes to be followed and who to report concerns to.

Is the service effective?

Good

The service was effective.

Most people had their rights respected because the principles of the Mental Capacity Act 2005 were followed; improvements were needed around the records. People were asked for consent prior to staff supporting them.

People who had recognised differences had adaptations made in line with their needs.

People benefitted from good medical and community healthcare support and staff were proactive in seeking advice.

People were supported by staff who had the skills and knowledge to meet their needs.

Is the service caring?

Good

The service was caring.

People's needs were met by staff who were kind and caring. Staff respected people's individuality and spoke to them with respect.

People's privacy and dignity were respected and supported by the staff.

People were able to make choices and these were respected by staff.

Is the service responsive?

Good

The service was responsive.

People's needs and wishes regarding their care were understood by staff because most care plans contained important information which was personalised to their needs.

People benefitted because when their needs changed most had updated care plans to reflect this.

People and their relatives knew how to complain and most thought action would be taken to resolve them.

Is the service well-led?

Good

The service was well led.

People were supported by a service where the provider and registered manager had robust quality assurance which identified concerns and took action to rectify them.

People benefitted from a service where the provider and manager supported staff and there was a staffing structure to provide lines of accountability.

People and others were able to make changes about the service as they were consulted about their views on how it could be improved. Actions had already started to be taken.

People were able to receive high quality care because the provider and registered manager were constantly striving to make improvements.

Somerset Care Community (South Somerset)

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 was announced and took place on 13, 14 and 15 December 2017 and 10 January 2018.

We gave the service 48 hours' notice of the inspection visit because it is office based and the manager is often out supporting staff or providing care. We needed to be sure that they would be in.

Inspection site visit activity started on 13 December 2017 and ended on 15 December 2017. It included talking with staff, looking at records, speaking with the management and visiting people in their homes. We visited the office location on 13 and 15 December 2017 to see the manager and office staff; and to review care records and policies and procedures. During the inspection phone calls were made to people who use the service and their relatives on 14 December 2017. Further phone calls were made to staff on 10 January 2018.

The inspection was carried out by three adult social care inspectors and two expert by experiences. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to this inspection the provider completed a Provider Information Return (PIR). We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We looked at other information we held about the home before the inspection visit.

We spoke with four people, two relatives and one health care professional during the visits to people's home. We spoke with 13 people and six relatives on the telephone. We spoke with the operations manager, a registered manager from another service, the manager and eight care staff. Following the inspection on site, we spoke with another three staff members on the telephone.

We looked at 10 people's care records and observed care and support when in people's homes. We looked at seven staff files, staff rotas, quality assurance audits, staff training records, the complaints and complements, staff meeting minutes, newsletters, medication files, statement of purpose, provider internal communication documents, and a selection of the provider's policies.

Following the inspection the manager sent us an action plan of improvements they were making since the inspection.

Requires Improvement

Is the service safe?

Our findings

People and their relatives had mixed views about whether there were enough staff to meet their needs and keep them safe. Feedback from people included, "Have care three times a week, they stay full time and are lovely and kind", "I have a carer daily, it's not regular at the moment, times vary", "I like to know who is coming. It never seems to be the same ones. I don't always get a rota. When I do at least I know who is coming" and "I have carers twice a day. Mostly the carers are on time. But the office mess you about they don't let you know what's happening if the girls are going to be late". Relatives said, "They come once and day and stay the proper amount of time", "The regular ones will come on time but the others will come any time" and "One person from an agency came last week and was not on the rota".

Staff had varied feelings about whether there were enough of them to keep people safe and meet their needs. One member of staff told us there were always two staff when someone needed it, for example, for moving and handling. Another member of staff said, "Staff are off sick so things have had to change slightly" and continued, the calls requiring two staff have times "Set in stone". Whilst others said, "At times we can run a bit thin", "There are not enough staff, we use agency and it can be very up and down, there are staff leaving" and "We are short staffed because staff have left, we are using agency now and sometimes they don't turn up." The manager had identified the need for additional staff so had organised several regular agency staff to work in areas where there were shortages. All the agency staff had received the company induction and training so they delivered consistent care for people.

The manager and the provider's PIR told us there had recently been some changes the way people's calls by the service were arranged. One of these was to have small teams in local areas with specific people to visit called 'pods' so there was consistency of staff and less travel time. Following the inspection the manager was going to send out a letter to all people and their relatives stating what the benefits of the changes would be. It would highlight the longer term benefits including consistency and shorter travel times for staff.

Some people told us they had too long a gap between the evening visit and the morning visit which meant they were unable to take their pain relief which resulted in them being in pain. One person told us they were unable to swallow their tablets whilst they were in bed. They needed care staff to help them get out of bed in the morning. One member of staff knew the person liked a "Nice early morning" visit. The person said sometimes they can be in bed 10 hours on their back. Their daily logs showed over seven days there had been at least 12hours between the evening visit and the morning visit. Their care plan did not specify details about the time they preferred their medicine. Another person told us because the morning visit was late they were unable to take a painkiller. This meant they ended up being in some pain. The manager told us they would follow this up and review the person's visit times. Following the inspection the manager sent an action plan about how they were reviewing all visits for people who required pain relieving medicines.

Most people told us when they received support with their medicines they were usually given safely and in a timely manner. One person said, "They put cream on my legs, they check the care plan first and then they write it in the book". When medicines such as liquids and creams were opened the bottle was dated to inform people it was safe to use. There were Medicine Administration Records (MARs) in place for people to

record when medicines had been administered. However, improvements were required. People's MARs did not always identify the medicine strength, dose, route or frequency of administration in line with current national guidance. This meant there was a risk staff could administer medicines incorrectly. One person's care plan had a sticky note at the front about an allergy to penicillin. There was a risk this could go missing and the information would not be available because it was not clearly documented in the person's records. By not having this information in the MARs there was a risk medicine would be administered incorrectly or at the wrong time. They also had a variable dose pain killer and there was no guidance, nor a record of how staff knew which dose to administer. Neither did their MARs record which dose had been administered by each staff. This meant there was a risk the medicine would be administered inconsistently or not in line with prescribed instructions.

Another person's care plan contained contradicting information about how their medicine should be managed. In one place the care plan instructed staff to remind them about medicine. There was no information about what to do if the person refused their medicine. One member of staff explained they had recently visited this person who refused their medicine. The staff member said, "Nothing about medication" in the care plan and they did not know if the person had dementia. A third person's care plan contained no guidance for staff about the support they required with their medicines. There was no information about the times medicines should be administered or which medicines the person was prescribed. For all people there were records to say no medicines had been missed. The operations manager told us the provider was introducing a new electronic care plan system. This would contain all the updated information and further reduce the risk of errors with medicine management and administration. Following the inspection the manager informed us a full review of all medicine administration records would be taken.

Most people with specific health conditions had care plans which provided guidance for staff to deliver their care. One person required special equipment to help them breath. Their care plan said, "Place mask over [name of person's] nose and mouth pressing quite hard to create a seal. Wait for the inhale and exhale then remove mask". However, there were occasions people's care plans did not contain enough information and records of how they had been supported were not clear. For example, one person at high risk of pressure related wounds had a care plan with minimal information. Daily records contained the same statement, "Moved up the bed" or nothing about repositioning. This meant could be placed at higher risk of developing pressure related wounds. During the inspection a health professional told us they were happy with the person's skin. They said, "[Name of person's] skin is beautiful". We spoke with the manager who was going to review how people with specific health conditions were recorded in the future to ensure it was in line with people's needs. The operations manager told us the new electronic system would ensure all care plans were updated and the care delivered was recorded accurately.

People and their relatives told us they felt safe when supported by staff in their own homes. During the visits, one person told us staff were always gentle when supporting them. People told us, "I do feel safe as they wear a uniform, I have a key safe and they call out hello when they come in", "Been having care for a long time, I feel the carers I have are skilled and safe with me" and "The ones that come seem experienced and I feel safe with them". Relatives said, "We find the carers are safe, experienced and pleasant" and "Yes, I think he feels quite safe with his carers, they wear uniforms and have a badge".

People were kept safe because the provider, manager and staff understood their responsibilities in relation to people's health and safety. One member of staff explained, "The independent living team will make sure it is a safe package of care". If the right equipment is not available then they will source it as part of the assessment process. For example, one person was unable to access their toilet when they arrived home from hospital. The team contacted a company to ensure an alternative commode was arranged. People were kept safe from infections spreading because staff wore protective clothing when they were supporting

them with intimate care. One person said, "They do wear gloves and aprons and they have a special bin to put them in". During the visits we saw all staff wore gloves and aprons to support people.

People were kept safe because most risks had been assessed and appropriate action taken to mitigate them. One person had risk assessments in place for using their wheelchair in the community and staff using their hoist. There was information about how their movement changed when excited. Another person at risk of pressure related wounds had risk assessments for skin integrity. Before a package of care had started an environmental assessment had been completed so staff and people could stay safe. Other people had detailed risk assessments for moving and handling. This included which equipment should be used, how many staff are required to support them and how. They identified how to mitigate risks such as ensuring the correct slings were used.

People were kept safe from potential abuse because staff understood how to raise an alert if they had any concerns about the person's safety. All staff introduced themselves when first starting to work with someone in their own home. One person said, "If I have a new staff member they come with someone else first and the ones that I have seen have always introduced themselves". One member of staff said, "If I thought there was anything out of the ordinary I would report it and I'm pretty sure they would take the right action". Other staff members would make sure the person was safe and knew they would have to write a report of what happened. All staff agreed action would be taken by the management. They all knew who to contact externally should this not happen. One member of staff said, "I am aware of the whistleblowing policy and have no qualms about using it". Some staff were working with younger people. They had all received specific training in relation to children's safeguarding.

The PIR told us and we saw people were supported by staff who had been through a robust recruitment procedure. This included checks on staff suitability to work with vulnerable people and references from previous employers. These were all completed prior to a new member of staff working with a person. One member of staff said, "All the checks were in place before I started". All staff who regularly drove for work had their current driving licence checked and documents relating to their car to ensure they were keeping themselves and others safe.

The provider and management worked hard to reflect on practices and looked at lessons learnt when accidents or incidents occurred. One member of staff said, "We record incidents and report them to the office, there's a culture of learning from mistakes looking at what happened and why and following this up". One person had a missed call because staff rotas had been changed. The lessons learnt recorded were that prior to all rota changes checks should be made with staff. There had not been any further recorded missed visits for this reason. On one occasion a person had missed a newly prescribed medicine. A responsive meeting with the member of staff identified the person's medicine records had not been checked prior to administering the medicine. The staff member completed a reflective log to remind them about the correct medicines procedure. No further errors had been made by the staff member. However, there were occasions when lessons learnt and actions taken had not been accurately recorded. For example, when it had been identified there were not enough staff for a specific area the actions taken of sourcing regular agency staff had not been recorded. The manager told us they would identify if staff completing them needed additional training. Following the inspection the manager had introduced a new system where they reviewed all accident and incident records.

Good

Is the service effective?

Our findings

The PIR told us and we found people were supported by staff who had the support and skills to meet their needs. One person said, "They do send well trained ones". Another person told us, "They do seem well trained". One relative said, "They do seem well trained". Staff told us, "The training is really good; you get what you should be for the role. They make sure your training is up to date" and, "All of my basic training is up to date and I've done other training too, they arrange that if you suggest it". One staff member told us they were completing a diploma in health and social care. Other staff told us there was training during meetings where specific tasks and changes could be discussed. When staff had been assigned to complete particular roles they had received additional training such as working with local hospitals to meet the needs of more complex people and the use of specialist feeding equipment.

The provider had systems in place to ensure people were receiving support from staff in line with the training. One member of staff said they felt supported. They had two recent 'spot checks' which were visits by management to ensure gloves and aprons were worn, equipment was being used correctly and they were providing support to meet people's needs and wishes. One senior member of care staff said, "We carry out regular observations on staff to check they are following guidance and risk assessments". Another member of staff told us they had two or three observations in last three months from senior members of staff.

New staff received a thorough induction and training prior to starting work. If staff were new to care they would complete shadow shifts and undertake the Care Certificate. This is a set of standards to ensure all people working in health and social care have the basic skills and knowledge. They had opportunities to shadow experienced staff. After six weeks they received a review about how the work is progressing and if there were any training requirements. The provider had identified a need for a further meeting with all new staff. This provided refreshers of policies and procedures. It also gave new staff an opportunity to share experiences.

People who were new to receiving support had a thorough assessment to identify their care needs and requirements. One member of staff said, "People have an assessment" and continued, "Normally it's all in the file. They tell us how they like their care". When a person was discharged from hospital with the view to manage living in their own home there was an independent living team in place. One member of staff told us their role was to visit people in hospital or their own home to write the care plan and identify equipment required. Where possible their aim was to enable people to live independently again. They would review the care after four to six weeks to find out if any changes were needed or further care was required. The member of staff explained if a person had complex needs they would liaise with the hospital prior to the discharge. This meant people's needs were thoroughly assessed and support was provided in line with their care and health needs. Staff told us if people's needs changed they would ask for the person to be reassessed. For example, if someone with a specific health condition had declined with their verbal communication they would seek advice from another health professional.

People were supported by staff who worked in teams and across organisations to meet their health and care needs. One health professional said, "They [meaning the care staff] are very good at reporting to us when

they have concerns". One member of staff told us when there were people with complex needs they would liaise with social workers who may have started the assessment process. If staff did not have the skills to assess someone's needs the management liaised with other health and social care professionals. For example, if the equipment currently in the home did not appear suitable then contact was made with occupational therapists for alternatives. However, on one occasion staff had not contacted relevant health professionals about the dietary requirements of a person who was eating a soft diet to ensure it was appropriate. The manager told us they would make contact with the health professionals to ensure the diet met the persons care and health needs.

People were asked for consent if they had capacity to make a decision. One person had consented to a lap restraint on their wheelchair and the use of a recliner chair. One relative told us, "They tell her what they would like to do to make sure she understands and agrees before they carry on". One member of staff told us if a person refuses their medicine then they will respect this and notify the office. They said, "I can't force her to take medication".

Some people using the service lacked capacity to make some or all important decisions because of illness such as dementia. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the service was working within the principles of the MCA and found most people who lacked capacity had their needs considered in line with current legislation. Staff knew how to identify when someone lacked capacity. The provider had a MCA advisor available for managers and other staff to speak with should they have a specific query. All staff were given pocket guides to MCA so they had a reference point if they were not sure. There were two occasions when people who lacked capacity had incomplete records. This meant they had not demonstrated their capacity had been considered and a best interest decision made in line with current legislation. The manager and provider told us they were currently developing the care plans and will be transferring them to an electronic system. As part of this process all paperwork for people who lack capacity would be reviewed. Following the inspection the manager told us further training for staff who wrote the care plans was being delivered.

People had their health and care needs reviewed by a range of professionals to ensure they were being met. One person had recently had a review which was attended by an occupational therapist, speech and language therapist and physiotherapist. Notes of the review stated, "[Names of relatives] advised they continue to be happy with the support [name of person] and they receive from Somerset Care". When specialists had been involved they provided guidance for staff to follow. For example, one person had pictures of how they should be hoisted provided by an occupational therapist. Staff knew to follow this advice.

People were supported by staff who knew how to recognise if their health was declining. One relative told us, "When they [meaning the care staff] were creaming his legs recently they found something. They did not like the look of it, so they spoke to me and we called the GP". One person had pink blemishes appear on their skin and staff identified this during intimate care. Staff immediately contacted the district nurses to get the person's skin checked. During the inspection a district nurse told us staff knew to help the person reposition when they visited to reduce the likelihood of pressure related wounds.

People were supported by staff who knew how to meet their dietary requirements when they were

supported with meal preparation. Staff made sure they asked people what they wanted and then respected their choices. One person had a joke with the member of staff about what they wanted for lunch. They said, "I am not having pickle with my cheese" and this choice was respected. Other people told us, "They [meaning staff] do ask what I'm having today and they will cook me cheese on toast", "They [meaning staff] will say 'what would you like for breakfast today?' Sometimes I have scrambled eggs it's up to me" and "I have microwave meals and they will ask me what I want and heat it up and serve it to me and they check I've got drinks before they go".

People were protected from discrimination by staff recognising each person as an individual. Some people had specific needs during their visits due to mobility issues and staff respected this. One person said, "They help me access my shower and step up in and out of it". Staff liaised with people who had verbal communication difficulties about how they wanted to communicate with them. One staff member told us they give additional time for a person to express themselves when they were struggling. They knew the person preferred to verbally communicate. Other people who had limited speech were spoken to in a kind caring way and staff waited for non-verbal responses such as smiling and nods of the head.

Good

Is the service caring?

Our findings

The PIR told us and we saw people were supported by staff who were kind and caring. One person said, "I am thrilled with the girls that come, I'd give them 10/10 absolutely". Other people told us, "They are lovely girls [referring to the care staff]", "I can have a laugh with my carers they show interest in me. I enjoy their company" and, "My regular one [meaning care staff] has given me a Christmas card. She's like family. She knows I like dogs and we will chat about them". People's relatives reflected the same view. They said, "[Name of person] gets the best of care", "Yes they are kind and caring" and, "They are caring people [meaning staff] on the whole".

During the visits we saw people were comfortable around the staff who supported them and there were positive interactions. The staff did not appear rushed and they stayed the full length of the visit. When members of staff left they checked people had all their needs met and said, 'Goodbye before departing. One person required eye drops because they had a sore eye. During the inspection a member of staff complemented the person on how much better their eye was. In response, the person smiled and seemed pleased at the positive feedback.

Complements we saw reflected the feedback we received about staff. This included comments from customer satisfaction surveys. For example, "Staff are kind and helpful" and "Nothing is too much trouble". The manager told us, "Staff are really passionate and they really care". The operations manager and provider explained they were striving to ensure people had a positive experience when receiving care. They told us some of the changes being made were to improve travel times and so each person had regular care staff.

People were supported by staff who understood how to respect their privacy and dignity. One person said, "The girls are wonderful, lovely can't fault them. They help me to shower and dress and they are dignified with me. They keep the door shut when I'm showering and getting dressed, so I don't get cold". Other people said, "They are respectful" and "They are respectful and they speak nicely to me, they check it's ok to wash me and they will encourage me to wash what I can manage". One relative told us, "They will close the door when showering him to respect his privacy".

One member of staff told us when supporting people with intimate care they, "Make sure front door is locked". They then described how they use towels to cover the person's body whilst they were being washed. If there were other family members at home they would make sure doors were closed. Other staff said, "I always make sure doors are closed and curtains are drawn, and cover them with a towel" and "When providing personal care I make sure the doors are shut, they are covered and I respect their wishes".

People were offered choices by staff and their preferences were respected. One person said, "I tell them what I want" and agreed the staff listened and respected their selections. One relative said, "Yes my husband is given choices about his care. They will ask him, if he wants a shower and suggest they shave him". During the visits we saw staff offer people choices about the food they would like and whether they wanted support with their medicine. When people had communication difficulties then staff would show them objects. For

example, one person was lying in bed and was asked what they would like for breakfast. They were shown a yoghurt and a bowl to represent porridge. The person could then point at which they wanted.

People's religious and cultural needs were respected by staff. One person's care plan said they followed the Church of England. Another person told us they like to go to prayer meetings in the building they lived at. The member of staff smiled and talked fondly about the friend who supported them to the meetings. They respected the choices the person made about their religion. The person's care plan reflected their religious beliefs.

Good

Is the service responsive?

Our findings

Most people's care plans outlined their daily routines which was important because some of them had memory loss and communication difficulties. People told us, "I have got a care plan I think it's up to date" and "I have got a care plan and it's up to date". One person had details about their intimate care preferences including instructions of how staff should help them. Another person had clear guidance for staff to follow about the support they would like with their care. Their care plan informed staff they would like assistance with their legs, feet and stockings. The information included instructions about getting a bowl stored in the bath and filling it with warm water. It went on to say which flannel should be used. Then it instructed staff to remind them to take their medicines.

During the visits staff were familiar with the content of people's care plans. One member of staff said, "The care plan will instruct me in what I need to be doing and risk assessments". They told us all the paperwork was in place in their experience. Another member of staff knew a person's bed was adjustable and what height it needed to be in the mornings. The person confirmed what they said was in line with their preferences and needs. Staff told us they get to know people they support. They said, "I have got to know people well" and "I have got to know them well; I chat to people whilst supporting them".

Most people's care plans were personalised to share their needs and wishes with members of staff. Some people had aspirations and goals highlighted in their care plans to provide guidance for staff about how they wanted to be supported. One person had an aspiration to help them become more independent. Another person had a goal of remaining at home through the support which was provided. They also contained additional information about what was important for people during the support they received. One person's care plan said, "[Name of person] likes to hold her tea towel as this provides a source of security and comfort". However, one person's care plan lacked sufficient information to guide staff. There was no information about the type of support they required or their daily routines. This meant there was a risk agency staff and new staff may not know how to support them to meet their health and care needs. The manager and operations manager told us about the care plans being changed to become electronic in the next few months once they had trained up staff. They would ensure all care plans were updated in this process.

When people had changes to their care their plans were normally updated. For example, one person had a change in their plan after a visit from the nurse. This provided staff with new instructions about how to support them. However, there were occasions when people's needs changed and care plans were not updated. One person had hurt their shoulder and their relative told us, "The care plan is quite old" and it had not been changed since August 2017. During the inspection staff were supporting the person in line with their current needs. One member of staff said, "Care plans and risk assessments haven't been updated due to lack of time". Following the inspection the manager told us all care plans were being reviewed to ensure people's needs and wishes were reflected.

Most people had reviews of their care plan. When people had them and asked for changes these had been actioned. One relative said, "She does have a care plan and I believe it has been updated in the last year. I

can't remember who came or what we did". One person wanted to change the time they were visited in the morning. The daily records demonstrated this request had been put in place so daily visits were now later. Another person had a review which read, "Very happy with care received. No concerns with care delivered by staff. Would prefer early visits at weekends". This change had been made.

People and their relatives knew how to complain and there were policies and procedures in place to manage them. When people raised complaints the management took actions to resolve them. One person said, "I do phone and complain sometimes" and then explained about a recent complaint they made. They confirmed action had been taken to resolve it. One relative had raised concerns about care staff, "Being a bad match". As a result, the care staff visiting them were changed and the outcome written up read, "More than happy with the care and carers. Does not wish to change anything". Another relative said, "We have never complained he is quite happy at the moment". Although we received generally positive feedback about complaint management, we did receive some feedback where people felt their complaints were not responded to or they did not receive an outcome.

Good

Is the service well-led?

Our findings

People and their relatives had mixed views about the management of the service due to recent changes. One person said, "Up until two to three weeks ago I would've recommended them. But not now because of all the changes. On the whole they were pretty good". Others made comments about the recent changes meaning visit times had changed and so had their regular staff. Another person said, "I do wish the management would fix the times when the carers come it seems like it it's getting worse lately". Their relatives reflected the impact the recent changes had on the support people were receiving in their own homes. The manager and provider were aware changes were currently having an impact on the service some people were receiving. They had clear actions in place to resolve these concerns. Following the inspection the manager wanted to make further contact with people and their relatives to clarify about the changes.

Most staff were positive about the management and working for the provider. A large amount of the staff we spoke with had worked for the provider for many years. This reflected their positive opinion of the work and the support they were given. One member of staff said, "I really love my job". Other staff said, "[Name of care manager] is supportive", "There are managers about and you can approach them" and "Managers are accessible by phone or you can pop in the office for a general chat".

The PIR told us and we saw people were supported by a provider and manager who were constantly striving to improve the service they received. One member of staff said, "There were absolutely good changes". The provider had recently trialled a new computerised care plan system in another one of their community services. This allowed staff to log electronically all care delivered and medicines administered prior to them leaving a person's home. Staff would be unable to complete the visit without undertaking all the required tasks. If anything was incorrect or there were errors made, alerts were immediately sent back to the office to inform senior staff. Additionally, people and their relatives were able to access parts of the system if they wanted. The visiting registered manager explained this would help reduce errors and help them to monitor the quality of care people were receiving in their own homes. As the trial had been a success they had plans to roll out the system across the whole of this service. They knew it would be a big task so had a clear plan of how they would ensure all staff received enough training to feel confident.

Another change the provider and manager were making at the service was to improve how staff worked and visits were planned. They were rearranging calls into small areas with named staff assigned to each area. The operations manager and manager explained this would ensure staff had closer calls so would not be as likely to held up in traffic. It would also mean people would have a core group of staff they would be familiar with. Most staff told us they thought this would help improve the service people would receive. However, there had been a lack of communication about the new changes to people which caused some confusion. People said, "One carer I had was experienced. Had them a long time. Would like that again, the ones I have are lovely though" and, "Up until the last few weeks I had the same regular carers for 10 years. But the last few weeks have been hell with all the changes with the new system. One of my regular ones, who came three evenings, has just been stopped. No discussion. I'm so upset and so is she".

People were supported by a management who had quality assurance systems which identified when improvements were required. When their audits identified issues, solutions were found to resolve them. For example, in one area they recognised there were not enough staff to meet the amount of visits currently in place. The manager contacted another agency to identify a group of staff they could regularly use. These agency staff went through a full Somerset Care induction and training so they were working to the same standards. The manager told us they will be completing 'spot checks' on these staff to ensure people are receiving high quality care. Another change which was made was to have the office opened six days a week to better reflect the seven day week they delivered care. The registered manager from another service told us this has been a positive change for people.

The provider and management completed a variety of audits to ensure people received high quality care which met their needs. When shortfalls were identified action was taken to resolve the issues. For example, one person's medication administration records were audited and seven unsigned days were found. Two staff attended further medicine administration training to ensure their practice was safe.

Members of staff felt supported by the provider and manager. One member of staff said, "They have gone above and beyond to help me carry on working" when diagnosed with a health issue. The management had regularly met with the member of staff and found alternative work they were able to do. The staff member continued, "Because of them it has kept me alive". They still met monthly to ensure the work being allocated was suitable and people were having their needs met. There had been consideration around suitable access in the office should the staff member's health further decline.

People were supported by most staff who knew they had lines of accountability. One member of staff said, "I have regular supervision and an annual review with my line manager every 4-6 weeks, its supportive I'm given tasks and realistic timescales". Another member of staff explained they knew who their line manager was. The manager was clear who provided them support and who they could go to for advice. They said, "There is always someone to ask. Have people higher up". However, there were occasions when staff were not as clear about who supported them. One member of staff said, "I haven't had a supervision in years, I don't know who my supervisor is". The operations manager and manager were aware the service had been through a number of changes recently. This included different managers. As a result, they were working with staff to provide clear lines of accountability and ensure support was in place for them.

The management recognised the importance of providing the opportunity for staff to speak with them on a more informal basis. One senior member of staff told us they now had 'drop-in' days a couple of times a month. This was an opportunity for staff to meet more informally with members of management so they could share positive experiences and discuss any concerns. The senior member of staff told us they, "Went down really well". They also held team meetings which were more formal forums to share information.

The operations manager told us every three months they had organised a day working in one of the offices. This was another type of informal meeting which their human resources department would attend. Staff would be able to learn about the benefits they could gain working for the provider and have the opportunity to speak with senior management. It was to provide further opportunities for staff to discuss recent changes at the service and raise any concerns they had.

The provider created opportunities for progression within their staff team as part of their drive to ensure stability within the service. One senior member of staff discussed the positive chances they had since joining the company. They explained they started as a care support worker and had been given options to complete secondments in different parts of the organisation including more senior positions. As a result, they had identified areas they enjoyed and had now begun a management qualification. The manager told us, "The

company are good at encouraging".

The provider had recognised new staff sometimes required additional support once they had been working for a few months. They had set up a 'new starter forum' which provided refreshers of important information and training. It also provided an opportunity for staff to feedback what was going well and any concerns they had. At one in September 2017 policies were reviewed, conversations about team work were held and a reminder about what do to if no answer at a visit. The operations manager told us, "The new starter forums aim to help staff retention".

The management told us they encourage feedback from people, their relatives and staff so they can make improvements and celebrate successes. In the summer of 2017, they had sent out a questionnaire for people and their relatives to complete. As a result, they had identified a number of actions to further improve the service people received. This included customer forums, encouraging people and their relatives to come to the office and involve people in staff interviews. The operations manager and manager told us one piece of feedback which prompted them to take action was around loneliness; they were planning to have small presents and cards sent to people on special occasions such as birthdays and Christmas. They were also going to arrange trips people could attend of which the first had been funded by the provider. For those unable to attend the trips the provider had purchased virtual reality goggles so alternative 'trips' could be taken. The operations manager told us they also had an arrangement so people could go and have lunch for a nominal amount of money at one of their care homes.

The PIR told us and we saw the provider had a long service award ceremony to recognise staff who had dedicated many years to supporting people in their own homes. Staff were given flowers and had a range of financial awards depending upon their length of service. Alternative awards were an extra day's annual leave. Staff were able to bring family members to celebrate their achievements. During the ceremony a person unknown to the staff came into the room and they were invited to join in the celebrations and were given a spare bunch of flowers. The operations manager explained this reflected the caring ethos the company were striving to create.

The provider had notified the Care Quality Commission of all significant events which had occurred in line with their legal responsibilities. They regularly liaised with the local authority including the safeguarding team. By notifying external bodies responsible for monitoring provider's people's safety could not be monitored.