Care Together Limited

Care Together Limited - 1st Floor The Corner House

Inspection report

Ringwood Road
Bransgore
Hampshire
BH23 8AA

Tel: 01425672255

Date of inspection visit:
23 September 2019
25 September 2019

Date of publication:
18 December 2019

Ratings

Overall rating for this service	Outstanding ☆

Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Outstanding ☆
Is the service responsive?	Outstanding ☆
Is the service well-led?	Outstanding ☆

Summary of findings

Overall summary

About the service
Care Together Limited – 1st Floor the Corner House, is a domiciliary care service providing personal care to 11 people aged 65 and over at the time of the inspection.
The provider was located centrally in the village with other amenities such as the post office and shops. People and their relatives regularly visited the provider when accessing other village facilities.
Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
The service was exceptionally safe. Staff had in depth knowledge of safeguarding and participated in regular training updates. Risks were assessed and actions to minimise unnecessary risks were put in place, however people were enabled to take calculated risks in order to lead fulfilling lives.
Medicines were safely managed and there were clear procedures should errors occur. Staff were safely recruited through scenario-based interviews to ensure they would reflect the values of the service in practice. The provider was constantly updating training in infection control and was creative in their approach.

The provider was exceptionally skilled at achieving positive outcomes for people they supported. Detailed assessments of needs ensured that care plans reflected relevant outcomes and people's needs under the Equality Act 2010. People were involved in the development and review of their care plans.
Staff were exceptionally well supported through regular supervisions and an extensive package of training. Support was given to staff to develop skills and the provider linked to other services in the area in order to access training that, as a small provider would not be cost effective to purchase.
Support with nutrition was creative, staff prepared meals for and ate with some people, took others out to cafes and lunch clubs and made comprehensive recordings to monitor food intake.
Very positive links had been forged with health and social care professionals and other service providers. This ensured that people had a seamless service when moving from hospital to home for example.
People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People and their relatives told us that the service was exceptionally caring and respectful. A group had been set up for bereaved relatives of people the service had cared for which had been opened up to relatives of people who had a poor medical prognosis.
A 24-hour on-call system enabled people to call for assistance at any time. Staff would often attend to someone during the night should they need personal care, or chat with them if they were upset. Priority was given to spending quality time with the person rather than completing a chore such as the washing up as the person may not see anyone else until their next care call.

New staff did not support people until the registered manager was assured they understood their role in maintaining people dignity. People and their relatives told us that staff were dedicated to ensuring people had quality of life.

The provider supported some people to transition to having care at home by providing domestic support in the home and gradually adding support with personal care. The provider was exceptionally responsive to emergencies and would adjust care calls to support people if they became unwell or needed additional support unexpectedly.

The provider offered a range of activities and supported people to access community events. They had been involved in setting up a dementia friendly ballroom class and regularly fundraised to provide additional activities for people such as visiting a local motorcycle museum.

Relatives told us they had been very well supported during the end of life care of their family members and the registered manager was proud of the way they supported people. For example, when a person had died, they would be dressed in a favoured outfit and items that meant a lot to them arranged with them. This had been comforting to relatives.

People and their relatives told us the service was exceptionally well-led, the manager and deputy manager received only positive feedback. The provider had been shortlisted for and received a number of care awards. Staff contacted us after the inspection to tell us how proud they were of the service and the support they received and provided.

The provider was holistic in their approach, though providing a service to one person, they would consider everyone in the household, the environment and support people in making future plans. The provider was committed to providing quality care and if unable to meet the specific needs of a person would signpost them elsewhere.

People and staff participated in quality assurance surveys. The registered manager was doing extensive work to develop new ways to obtain feedback as surveys were unpopular with people.
The provider had positive professional relationships with health and social care professionals, local businesses and care homes and were well known in the local community.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection
The last rating for this service was outstanding (published 21 March 2017).

Why we inspected
This was a planned inspection based on the previous rating.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Care Together Limited – 1st Floor the Corner House on our website at www.cqc.org.uk.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Outstanding ☆

The service was exceptionally caring.

Details are in our caring findings below.

Is the service responsive?

Outstanding ☆

The service was exceptionally responsive.

Details are in our responsive findings below.

Is the service well-led?

Outstanding ☆

The service was exceptionally well-led.

Details are in our well-led findings below.

Care Together Limited - 1st Floor The Corner House

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.
The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 19 September 2019 and ended on 25 September 2019. We visited the office location on 23 and 25 September 2019.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and

improvements they plan to make. This information helps support our inspections.
We reviewed information we already held about the service and sought feedback from health and social care professionals. We used all of this information to plan our inspection.

During the inspection
We spoke with one person who used the service and eight relatives about their experience of the care provided. Many people had a relative or friend who spoke about their service due to their condition. We spoke with four members of staff including the registered manager, deputy manager, and care staff. The registered manager was also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.
We reviewed a range of records. This included three people's care records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
After the inspection we were contacted by two staff members who wanted to share their experiences of working for the provider with us.

Good

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse
• The provider had extensive policies and procedure which protected people from the risk of abuse. Policies covered safeguarding during recruitment, the providers responsibilities to report people not suited to working in a caring role, whistleblowing and protection of children and adults.
• We asked staff what they might consider to be a sign or symptom of abuse. One staff member told us, "Any marks, bruising, worries about money or financial things, missing items. Pressure areas, unexplained marks, medicines errors, not errors but malicious things like hiding someone's medication."
• Staff had very clear awareness of what actions to take, they would speak with the registered manager, go directly to the local adult services safeguarding service or speak to an external agency such as Care Quality Commission.

Assessing risk, safety monitoring and management
• People and relatives told us the provider kept them, or their relatives safe. A relative told us, "Yes he is safe with them, they are always on time and always stay the allocated time." A person using the service said, "I am absolutely safe with them." People were able to get to know staff members due to the provider maintaining small teams to support individuals. This meant that if something were worrying them they felt safe and supported to tell staff, enabling staff to act and deal with their concerns.
• People receiving a service from Care Together were assessed for risks. All assessments were reviewed at least annually or when there were changes to the person's needs. If a person had bed rails, the provider sought written confirmation of this and an authorisation from the GP, occupational therapist or physiotherapist was on file when bed rails were in use.
• Moving and assisting risk assessments were in depth and covered both the person and the staff member's needs. This ensured that people had a positive experience of being supported when hoisted for example.
• Environmental risks such as access, trip hazards, floor coverings and the condition of any equipment were assessed. Risks connected with breathing, wounds, emotional wellbeing, memory and orientation for example were assessed for each person receiving a package of care from the provider.
• Each person had a personal emergency evacuation plan, (PEEP). The provider also strongly encouraged people receiving a service to have a visit from the local fire service which the provider would organise for them. The provider encouraged people to consider vibrating alarms and flashing lights if they had difficulties hearing audible alarms.
• Staff either attended group fire training or had one-to-one support from the registered manager.
• If risks were found in people's homes, the provider supported people to address the risks. In one case, the provider had managed to get a landlord to address water damage and a malfunctioning heating system. This enabled the people living in the home to be more comfortable and have improved health and well-being. The provider was proactive when advocating for the people they supported.

• There was a commitment to enabling people to lead happy, healthy and safe lives and the provider would challenge anything that was preventing this.
• The provider ensured that people were still able to lead fulfilling lives whilst reducing risks. To have positive life experiences, people were supported to take risks by accessing community events and being supported to have new experiences such as ballroom dancing and having a trip in a motorbike sidecar. If the provider were able to support someone with an activity they would do so.

Staffing and recruitment
• Staff were safely recruited, and all necessary pre-employment checks were completed, including for example, completing a Disclosure and Barring Service check, obtaining references and a full employment history. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.
• The registered manager interviewed all candidates and told us they would not employ staff who did not reflect the services values in their work. To avoid such situations, the provider had introduced scenarios to the interview process.
• The registered manager told us that when recruiting staff they looked for, "Something that is in you, there are not enough people who have genuine care in them. They need a kind heart, common sense and a willingness to learn, we can teach you the rest."
• The provider had employed several retired nurses who no longer maintained their registration but bought a wealth of knowledge and skills to the role of care worker.

Using medicines safely
• People received appropriate support with medicines. An assessment was completed to consider whether people could self-medicate or if they needed support with medicines. Most medicines administered by staff were supplied in monitored dosage systems, (MDS). An MDS is prepared by a pharmacist and arranges a person's solid medicines into a device with compartments labelled with day and time to administer.
• If someone was prescribed additional medicines, not included in their MDS such as antibiotics, a medicine administration record, (MAR) sheet was added. The first visiting care staff member would complete the form and a second staff member would check it and sign if correct so that hand written MAR's were dual signed as per good practice guidelines.
• Staff were trained and checked for competency before supporting people with medicines. This was updated annually and any new information about either medicines people were being supported with or good practice were communicated to staff immediately. For example, one person had been prescribed a medicine in tablet form which could potentially affect people handling it. All staff had been informed about this possibility and used gloves if a need to handle it arose.
• If there was an error in administering medicines, the registered manager would score the error according to the impact on the person and the nature of the error. The score would indicate the action required such as retraining in medicines administration, disciplinary action or reflective learning.
• Staff members supported people with food and fluid thickener. The registered manager was aware of the high risks associated with such products and risk assessed each person to see where the most appropriate storage would be. For example, if a person was living with dementia or someone else in the house could be at risk, a locked box was supplied with a key safe to ensure the granules were not accessed.

Preventing and controlling infection
• Care Together provided staff with personal protective equipment, (PPE). There was no limit to the amount of PPE given to staff and it included gloves, aprons and anti-bacterial hand gel. Additionally, staff would carry supplies such as incontinence pads and wipes in case the person they were supporting had run out.
• The provider also ensured that in the event there was soiled laundry in people's homes that they had not been able to wash, it was placed in soluble laundry sacks until the next care staff member visited both to

minimise the risk of contamination and to make the home more pleasant for the person.
• Staff received regular updates to their infection prevention and control training. The deputy manager had included innovative practical tasks to illustrate the spread of infection through poor hand hygiene. One exercise used coloured paint applied to hands. This showed, as staff touched things, drank their coffee, wrote notes etc., how far bacteria could spread if hands were not properly washed after supporting people.
• The deputy manager had attended 'train the trainer' training in infection control. They were continually trying to improve staff practice either through training, spot checks or audits.

Learning lessons when things go wrong
• The provider reviewed any accidents and incidents to look for themes and patterns. Each incident was considered individually and from it, learning such as needing to refer a person to their GP, or needing to support them to adapt the home environment would be taken.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• An enquiry form was completed for all new referrals before they received a service from Care Together. The form provided basic information about the person, their needs, any specialist equipment needed, any memory loss and their mobility level. These areas were developed into full care plans.
• People who were initially reluctant to accept care but whose relatives had identified they needed additional care, were supported to become accustomed to care staff by them completing cleaning and shopping for example. Once they were familiar with staff, additional support would be planned with the person including personal care as needed. While supporting the person with non-regulated activities, the provider would be continually assessing them and devising the safest and most effective ways in which to meet their needs.
• We asked the registered manager how they addressed the needs of people whose needs were covered by the Equality Act 2010's protected characteristics. They responded that the service provided person centred care which meant that everyone was assessed and planned for as an individual which addressed any specific needs under the Act.
• People, their relatives and relevant others were encouraged to contribute to care planning. Care records we saw had lots of information about people's lives, likes and dislikes and preferences which had been provided by people and their relatives. All the relatives we spoke with told us they had been involved in the care planning process and that they found it positive.
• The provider had information about different cultural and religious needs which, when relevant was used when assessing and care planning with people. Information about peoples observed religion was collected and the provider checked whether they were practising and if there were specific supports needed to meet these needs.
• The provider was a member of various professional forums and subscribed to updates from them and organisations such as the Care Quality Commission. The deputy manager was involved in training forums with the local authority and maintained a current knowledge of good practice. The registered manager maintained their registered nurse status. Information from extensive ongoing learning ensured people were assessed in the most current and holistic manner and that their support outcomes were wholly individual.

Staff support: induction, training, skills and experience
• New staff members completed an in-depth induction on commencing in post. Reviews and supervised practices took place during a probationary period and staff and the management team gave feedback on their progress so far.
• One aspect of staff members induction was shadowing colleagues on care shifts. They would observe, work with and be observed by other care staff until they were competent both in terms of skills and confidence to

provide care without additional support. If, during the induction period, the registered manager was concerned about their skills, additional training would be provided. If the new staff members attitude did not reflect the values of the service after additional input, the staff member would not progress into a permanent role with the service.
• The induction was very specific. The induction checklist completed by staff included a list of tasks to complete such as assisting with a bath, a body wash, supporting with medicines, applying cream to people, supporting people with convenes and applying a compression stocking. The list of tasks included all areas that a care staff member could expect to support people with.
• Staff met regularly with the management team, a supervision contract was signed to agree they would meet regularly for 20-minute sessions. Meetings could be spot checks, supervised practice, and informal and formal one to one sessions. Following observed practices and spot checks, people were asked for feedback about the staff members support, any issues raised would be fed back to the staff member so they could adapt their practice. Staff were encouraged to be reflective about their practice and appraisals included both a manager's appraisal and a self-appraisal which ensured staff were self-aware and understood the impact of their actions.
• A staff member, when asked about the support they received told us they felt valued. They said, "Very much so, [supportive]. [Name] is the registered manager and they look after us. Care staff are generally not valued either financially or regarded favourably but here we are looked after."
• If there was a new care package, new equipment or an unusual medical condition, the management team would provide additional support to staff and would use the situation as a training opportunity with the person's permission.
• The registered manager was very supportive to staff members who had conditions such as dyslexia. They had supported one staff member to attend external training even though they were reluctant due to their condition and ensured that all staff, regardless of any learning disabilities, were able to pursue qualification training.
• Training included sessions provided by the registered manager and deputy manager who had both completed train the trainer qualifications, and sessions provided by other professionals. There was a Dementia Friends Champion on the team. The registered manager was also looking to share training with other providers locally, so they could all access costlier opportunities.
• The provider utilised scenarios in the training sessions for medicines and mock MDS packets and MAR sheets with errors were also used to ensure staff could check that medicines were given correctly.
• The registered manager was a registered nurse and their extensive knowledge of medicines had been useful when explaining how medicines worked and processes such as use of a syringe driver to people and their relatives. In addition, the good working relationship with the district nurses meant they had training when a new medicine was prescribed which required specialist handling. This ensured people had support as per good practice guidance.
• The registered manager had supported staff to become champions in different areas. They had completed additional training and supported colleagues with their learning. When we inspected there was a safeguarding champion and an equality and diversity champion. Additional staff were developing specialisms in mental health and diabetes and completing a business management course.
• The registered manager and deputy manager ensured they maintained their continuing professional development and attended a variety of sessions such as provider forums and local authority provider events.
• The provider was exceptionally supportive to staff. Traveling time was included on staff rotas and was paid. Travel time was also based not only on the distances staff needed to travel but by both their mode of transport and driving style. If someone were a slower, less confident driver they were not pressured to get to a care call.
• The providers office was central to the village in which much of their care was delivered. The registered manager had set up an area for staff to spend time between calls for a break, to complete training and for

meetings. This ensured the wellbeing of staff.

Supporting people to eat and drink enough to maintain a balanced diet
• The provider supported people to have as much choice in their diet as possible. Some people were supported to go shopping. Taking people who had poor appetites to the shops sometimes improved it as they were able to see lots of different foods, smell the bakery and see the fresh fruit and vegetables which might remind them of an old favourite meal or suggest a new flavour to try.
• People and their families were happy with the support provided with food and drink. One person told us, "They prepare my lunch and give me drinks and always put it within reach for me, and they are always washing their hands and wearing gloves." A relative told us, "He can feed himself and they will put his food in front of him and consult him about what he wants. They do some of the food shopping."
• When supporting people with dementia, the provider always offered two choices and if not successful then use a process of trial and error to learn what the person liked.
• The provider had identified that some people would eat with other people but not alone. Staff members were allocated to attend and have their own lunch with a person. The care plan included staff eating with the person or taking them to a local café for lunch. Another person would only eat food prepared for them if someone else ate it as well. Staff cooked them a meal from scratch and sat and ate it with them. This gave the person confidence to eat which had improved their health and wellbeing
• When people had unplanned weight loss or had conditions that may cause them to lose weight, staff weighed them regularly. Charts for fluid intake and nutrition were used when needed and foods that hadn't been eaten were recorded with the same importance to the foods which were eaten as it informed staff what people may not like if they were unable to tell them.
• When preparing food for people, staff would ensure presentation was done in a person-centred way. For example, some people were put off by having a full plate. Staff served their meals on a larger plate or gave two smaller portions to encourage them to eat well. Other people might prefer snacks to 'graze on' throughout the day so sandwiches and other items would be positioned where they knew people would see them and eat them.
• The provider was able to support people with more specialist nutritional needs such as diabetes, pureed food, food and fluid thickener and people who had their nutrition through a percutaneous endoscopic gastrostomy, (PEG). Training specific to each situation would be arranged before support was provided. Staff would also provide information for professionals such as speech and language therapists, (SALT).
• The provider was person centred in their approach and respected peoples cultural and religious needs. This included an awareness that some people of faith may need food specific to their beliefs. This would be thoroughly researched and discussed with the person and their relatives as appropriate to ensure that meals were correctly prepared. They were also able to support people who were vegetarian or vegan and ensured that people had their wishes around food respected.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• The provider had forged good working relationships with local health and social care professionals, other domiciliary care providers and care homes. This enabled them to signpost people to other relevant agencies.
• The provider had good links to the local GP surgeries and district nurses. One person would regularly book GP appointments for no reason or forget why they had booked them. The provider visited the person to find out if they remembered the appointment and would then attend the appointment with them. This had been beneficial to the GP as the person often didn't arrive to booked appointments, and to the person as they were getting the healthcare support they need.
• The registered manager was able to telephone for district nurse input without a referral from the GP. This meant that necessary care was not delayed. During end of life care, access to district nurses was 24 hours a

day.
• The provider ensured that people had regular medication reviews, either through the local pharmacy or by their GP. This had an impact of people being enabled to change their medications to ensure they were taking only what was necessary.
• The registered manager had arranged with social services to have two people supported by the same social worker. They were married and initially had two different workers. Decisions about care needed to be made considering both people's needs and wishes and having just one contact made this easier for all concerned. The impact of this was a more joined up service for the people.
• During our inspection, a person with complex healthcare needs was being discharged from hospital. The provider immediately reinstated the person's morning care call and allocated staff to remain there until the person and their spouse, both of whom were living with dementia were settled. The provider spoke with the person's GP and staff had a new prescription filled for them.
• The provider ensured that people had oral hygiene care plans. Needs were identified including whether they had their own teeth or dentures. Support was put in place when needed, for example, someone may be able to care for their dentures but need some support or prompting to clean their own teeth. An outcome of a healthy mouth and good oral hygiene was the goal.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.
When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.
• The service was working within the principles of the MCA.
• Staff participated in training on the MCA during their induction and participated in regular training updates. The ethos of the MCA was embedded into the service provided and staff approaches to people. All staff we spoke with were able to tell us the principles of the MCA.
• We asked a staff member about the MCA. They told us, "I do it now without thinking. I assume capacity and offer choices. When I write care plans it is quite a lot to do. We offer choices and if people who have capacity are making poor decisions have to support them." They went on to tell us if someone lacked capacity they would consider making a best interest decision for them. They said, "When we need to, we link with the Becton Centre [mental health team], GP's occupational therapists, we look at what they [person] can do and the least restrictive option to keep them safe."
• Care plans held information about people's capacity, their ability to make decisions, how best to support them to make decisions, best interest decisions as needed and copies of lasting power of attorney, (LPA) documents for people who had them in place.
• People or their representatives had given consent for all aspects of the care provided by Care Together. We saw signed consent forms in people's care records. A relative told us, "They are all well trained and always ask his consent before they do anything."

Outstanding ☆

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as outstanding. At this inspection this key question has remained the same. This meant people were truly respected and valued as individuals; and empowered as partners in their care in an exceptional service.

Ensuring people are well treated and supported; respecting equality and diversity
• The provider had appointed an equality and diversity champion who was developing skills and knowledge in this area to support the staff team.
• People told us that staff were exceptionally caring and went the extra mile to provide quality care to them.
• People and their relatives told us they felt cared for and respected by staff from Care Together. One relative told us, "Both my parents were spiritual, but the staff would not have cared if they were Muslim or Christian, they would have treated them exactly the same." They went on to say "They (staff) gave me a special nightie for her (relative) at no extra charge that made it easier to toilet her, and also a feeding mug, it put a smile on her face. The care plan was excellent, and everything logged on it so that I could see immediately what was happening with her care. They are happy, confident staff who care about the whole family, they always asked how I was doing and would fit around me. They treated her with the utmost dignity and respect and indeed us as well. I was involved in the planning process for her care and it was just excellent."
• A person using the service said, "They are all very caring and kind, and know exactly what my needs are. I have regular care girls. They all know where everything is here in the house. They always ask me for my consent before they try and do anything for me."
• A relative told us, "They always treat him and mum with respect and ask for consent before they do anything, they don't just get on and do it. I was involved in planning their care at the start and it is reviewed regularly verbally. The carers they have are regular ones and obviously if one is on holiday a different one may come but they are all so professional it does not matter at all"
• The registered manager had identified there was little support for bereaved people and set up a group to support them. The registered manager, once the group was up and running, took a lesser role and the group became self-sufficient though still linked to the provider. They extended group membership to relatives of people who had received a poor prognosis as group members felt they would also need support as they could say what they were feeling without judgement to people who understood.
• The group has, for many years, arranged a garden party hosted by a relative of a person cared for by Care Together. The provider supported the relative throughout the care and loss of their person and then supported them to become confident to host the party. The group cater the event and support people who use the service, their relatives and other local people who were lonely or in need of support.
• The deputy manager told us they had taken their baby to the party and people had enjoyed holding them and interacting. They also took the baby to see a person who had been really interested in the baby since knowing it was expected. They retained the babies name even though living with dementia and showed joy when seeing him.
• The provider still oversees the group and signposts people to it as needed. The provider also has an open-

door approach to people, offering support to those in need who visit the office.
• The provider had supported a person who was bedbound to 'attend' the funeral when their spouse died. They were unable to attend the church service, so the registered manager arranged for a staff member who shared the person's faith to mirror the actual funeral at the person's bedside. The person's relative and several care staff attended the 'service' at the person's bedside. The same readings, prayers and hymns were at both services and they commenced at the same time. The person felt completely included in the funeral. A staff member told us they had felt honoured and privileged to have been able to do this for the person.
• People could access staff via the on-call system and the registered manager told us they regularly went out during the early hours to support people with personal care or other problems. Some people had the on-call number as their contact for their alarm, if they fell or became unwell and pushed their alarm, the provider would be contacted and attend. Another person had used the on-call system for a chat, they would phone very late at night as that was when they were in low mood and needed support.
• The registered manager told us they would, for some people, prioritise sitting with the person and having a conversation over doing the washing up. The staff members completing the care calls may be the only conversations that some people have in a day. These were more important to them than some tasks which could be completed at a later call.

Supporting people to express their views and be involved in making decisions about their care
• The provider was supporting a person who had no relatives. They had capacity but were elderly and frail. They had a friend who represented their interests with the provider and the provider had directed the person to the local solicitor and a lasting power of attorney, (LPA) was now in place. An LPA is a legal document that lets you appoint one or more people to help you make decisions or to make decisions on your behalf.
• In addition to assisting the person to formalise their arrangements, the provider, the solicitor, the LPA, and an overnight carer employed directly by the person would meet every three months with the person's knowledge and permission to review provision and ensure the person has everything in place that they required. The provider was the link between all aspects of the person's support network and ensured that all aspects of their care such as limiting staff to six people doing regular shifts and having a visitor's book so that they knew who had attended was in place to minimise the impact of their short-term memory loss.
• The persons attorney told us, "I could 100% raise things, I know most of the girls [care staff] and the registered manager and administrator. If I had any concerns I would pop in and discuss them. I can truthfully say we work well together as a team."
• Care plans included a section on people's disposition. One person's read, "[Name] chooses their own, smart clothes, this helps them maintain their sense of self." Additions such as this to people's care plans offered an insight into ways in which staff could ensure their well-being was maintained.

Respecting and promoting people's privacy, dignity and independence
• Staff participated in training which aimed to teach them how to support people in ways that were respectful and maintained people's dignity. The registered manager delivered this training and told us they would not allow staff to progress on to shadowing their colleagues until they were certain they had fully understood their role with regard to people's dignity.
• Training in this area had been developed by the provider using scenarios. These gave insight into staff members' attitudes as well as their skills.
• A person using the service told us, "They will guide me when help is needed but also let me do things for myself."
• A relative told us, "All carers [care staff] have a dedication to quality of life. They are delighted to see people, [name] used to kiss [care staff] goodbye. Staff give professional care, dedication and togetherness." They went on to say, "Not one Care Together staff member treats the role as a job. Their communication is brilliant."

• A relative said, "This is a good employer, they give staff the time to do what they should do. For example, [person] has a two-hour slot for a shower which seems a long time. It gives leeway to do it properly, the girls don't feel rushed, [person] needs to do what they need to do at their own pace. If you saw them, you would see they are always well presented." Staff were able to take enough time to enable the person to complete aspects of their own care, which was valuable as it meant they were retaining their independence.
• The provider ensured they kept people's care calls available to them even when they had a long stay in hospital. Care slots would be offered to other existing customers who wanted calls at a different time but strictly on a temporary basis to ensure that the person had suitable care on their return from hospital.

Outstanding ☆

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as outstanding. At this inspection this key question has remained the same. This meant services were tailored to meet the needs of individuals and delivered to ensure flexibility, choice and continuity of care.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• The provider continually fundraised so they could take people on outings and provide leisure opportunities. The registered manager told us they were concerned as people who received care at home were at risk of isolation and sitting lonely until the next carer arrived.
• The registered manager and staff took a stall at the local fun day and information shared about care at home and used the stall as a recruitment opportunity. They also generated funds for trips.
• An exceptionally successful trip was to a motorbike museum. Four gentlemen who usually had few opportunities for community access went and seemed to transform from four people living with dementia and to four men who were chatting constantly about motorbikes. They seemed to be young men again. They shared memories such as taking a wife in labour to the hospital in their sidecar and riding in the Isle of Man TT races.
• A person receiving a service was keen to start ballroom dancing sessions. The provider helped them to find a session and a care staff member supported them to attend for a few weeks. However, they found the group was too fast paced. The provider arranged for the person to attend after the main group and enjoy a more leisurely paced session. They were soon joined by several other people, all of whom were living with dementia. The impact of supporting the person to attend the dance class was that a specialist dementia friendly dance session was started for people in the local community to enjoy.
• Some people had social calls in addition to care calls. These involved staff spending time with them at home or taking them out. The registered manager told us that she was fully aware that when providing social support, staff frequently took people out for much longer than their booked call to make sure they had a positive outing. This was done in staff members own time because they enjoyed spending time with the people they supported.
• One person was supported in employment locally. They had been affected by a significant medical condition however still wanted to work as they had previously enjoyed a successful career. A job was found, and staff provided necessary support for them to attend and make the most of their employment.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• People were assessed before receiving services from Care Together.
• People and their relatives were actively involved in the care planning process. Reviews were annual or as required and the all relevant parties were included. Reviews could be an informal chat or a more formal event at the providers office including health and social care professionals and legal representatives.
• All people and relatives that we spoke with told us they were involved with their care plan, had unrestricted

access to it and could, at any time, contact the registered manager if they wanted it updated.
• For one person, they received their weekly rota, but it was only supplied showing arrival times for staff. This was because the person became upset if they knew when staff would leave them, they loved the support and company that staff members gave them. This minimised distress for the person.
• The provider was able to respond in emergency situations. When a person became unwell, the provider contacted the person responsible for making their decisions and offered additional care slots until they recovered. The instant response was appreciated by the decision maker and the person.
• In a second emergency, a staff member attended a person's care call and found they were having a serious medical emergency. They called for paramedic support and contacted the office. The registered manager arrived before the ambulance and supported the staff member to provide lifesaving care until the ambulance and subsequent air ambulance arrived.
• The provider used a system of recording which enabled staff to provide care that was responsive to people's needs. The provider had designed records which were appropriate for each person. For example, there was a food record sheet. For one person this included space to record their blood glucose levels as they had diabetes. If blood glucose levels were not as expected, staff members would phone district nurses or the GP for instructions. For another person there was room to record what food they were offered, how much they ate and how much was thrown away. This was so staff could ensure they prepared food that the person enjoyed and to and prevent them from wasting money on food the person no longer ate. They were living with dementia and experiencing problems with eating, the form had improved the amount consumed.
• There were only female care staff when we inspected the service. This was due to not having male applicants for jobs. If someone was not comfortable with female carers, the registered manager would work with them to plan a way to provide care they were comfortable with or signpost them to a different provider of care. One person wanted to use the provider though they preferred a male staff member. The registered manager worked with them and devised a means of providing care such as bathing so they remained covered and not exposed. The person was happy with this and continued with the service despite there being no male carers.
• The provider used an electronic application to support their care calls. The system would alert them if a call was not made and provided an additional platform for communicating with staff. If care calls were being cut short by staff, the system would alert the management team of this and it generated useful alerts such as risk assessment and care plan review dates and people's birthdays.
• The system also enabled accurate billing and pay for staff. If a staff member left a call after 30 minutes instead of 45 minutes, they would be paid for just the time worked and the person would be billed the shorter time. If they stayed for an hour instead of 30 minutes they would be paid the hour and people billed for the hour.
• A relative told us, "They seemed to have different staff for different things, they were happy to listen to [names] stories, they had absolutely the right people for different skills. Once I mentioned that [person] was not getting enough exercise and they sent someone along to teach us both chair-based exercises. We call them the pink ladies in this village, they are excellent."

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• Peoples communication needs were assessed and planned for on commencing a service with the provider. Information was held about any aids such as spectacles, hearing aids
• The provider had large print copies of information available for people if they were not able to manage standard print. They would also make bespoke enlargements of documents to ensure that people could

manage to read information.
• The area the provider served had few non-English speaking people however the provider had found appropriate translation services should the need arise to have information given in a language other than English.
• One person who had a significant visual impairment was supported to consent to care and agree care plans by having them read out by staff members. Once verbal consent was obtained from the person, the documents were sent to their lasting power of attorney who would sign on their behalf. This ensured that the person was able to give consent themselves and the provider had a legal consent in writing.
• The provider ensured that information for reviews and quality assurance was sought in a person-centred way. Some people could respond to paper-based requests for information while other people, those living with dementia, were better in a conversation setting. The registered manager spoke with people at different times of the day as people may respond better at different times, so would get feedback from conversations had when preparing meals or supporting them with care.
• The provider ensured that when they were assessing new people they sought clear information about their advanced wishes should they have any. They sought these and ensured that the person, their relatives and medical professionals were aware of them, as in the event that the person became unable to convey their wishes the records would ensure they were cared for as they wanted.
• The provider used a noticeboard outside of their office to communicate with the community. They added a variety of quotes, inspirational remarks and information that tried to promote care at home and dispel any negative beliefs about it.

Improving care quality in response to complaints or concerns
• The provider had a clear complaints procedure which was used for both formal and informal complaints. When we inspected there had been no specific complaints however they had dealt with a concern raised by a neighbour of someone receiving a service. The neighbour complained to CQC and posted on social media however when they were supplied with a complaints form did not complete and return it.
• The provider was proactive, if people had any concerns they would deal with them thus preventing complaints. People we asked all knew how to complain and were confident that the provider would address their concerns.
• A relative told us, "I have never had to complain but I know if I did they would listen and do all they could to put things right for us. If I needed to, I would go to the manager, but as I say it has never happened. I can't praise them enough really."

End of life care and support
• Care Together provided exceptionally good end of life care. The registered manager was a registered nurse who had completed additional training to verify deaths and to support people at the end of life.
• End of life plans were in place for some people, not everyone wanted to complete one. One person had an advanced decision in place. They wanted the provider to support them to find a care home if needed however had also made plans to remain in their own home being supported by them.
• The registered manager told us of a person they supported at the end of life. There was a 24-hour care worker from another provider working with the person and Care Together had supported with a second staff member.
• When the person was close to the end of their life a member of staff stayed with them. Following their death, the staff ensured that the person was dressed in the clothes they had said they wanted to be dressed in and had items close to them which they had specified they wanted, religious items and treasured things which represented who they had been in life.
• Relatives were called but did not arrive until after the person had died. They telephoned when they were on their way to see how things were, and the provider told them "We are with them, holding their hand." Rather than deliver the news that the person had already died over the phone.

• Following the death, the registered manager received thanks from a relative saying, "Thank you again for arranging that [person] was in their favourite dress. Also, for placing all those items around them. When the time came it seemed appropriate to let the prayer and Arsenal books go with them. I have since requested that they remain in that dress…. So once again, thank you for preparing everything before I arrived. It made the last hour I spent with them so much better."
• The registered manager had considered all aspects of end of life support and the support for relatives afterwards. They recognised that the situation, while still distressing, could be made easier and more comforting for relatives and worked towards this.
• The provider was responsive to changes when providing end of life support. The registered manager told us they would try to make sure there were no more than two people receiving end of life care at any time as the pressure in terms of ensuring that staff who knew the people well were available and the emotional strain that staff could experience needed to be kept to a minimum. Clearly should the need arise the service would provide the care required however the registered manager would work to cover additional care needs to ensure staff were not overwhelmed.

Outstanding ☆

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has improved to outstanding. This meant service leadership was exceptional and distinctive. Leaders and the service culture they created drove and improved high-quality, person-centred care.

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

• The provider intended to continue to provide quality care to people local to the service. They did not intend to grow the business significantly as they were concerned they would not be able to know all the people they supported.

• The service was exceptionally well-led. A relative told us, "They are just so organised and well managed. If I ever needed to change anything it was done at the drop of a hat. They gave us confidence when it was most needed. I would recommend them to anyone, someone in the village recommended them to us. We did some feedback over the years, but it was always positive, and I cannot fault them at all, they just go that extra mile to help you in any way that they can"

• A person using the service told us, "I know who the manager is, and the service is very well managed. I have been asked for feedback, but nothing has changed as nothing needed to change! I would recommend them to anyone, they are just so good."

• A friend of a person using the service spoke to us about the registered manager and said, "[Registered manager], I have never met someone as caring, their background knowledge and understanding nature of what needs to be done is exceptional. They don't charge to attend meetings about the [person] and is very passionate about care for everyone. They give what they would want for their own mum."

• All the feedback from people and their relatives about the management of the service was very positive and everyone we spoke with would recommend the provider to others.

• Since our last inspection, the provider had won the 'Care Provider of the Year' award, presented by the Hampshire Care Association. They were runners up for the same award in the following year. A staff member was also a runner up for an award. Following this inspection, the provider has achieved runner up in the 'Home Care Provider of the Year 2019' category and both the registered manager and deputy manager were shortlisted for individual awards achieving winner and runner up in the 'Home Care Non Care Employee of the Year 2019', the category awarded to managers of services.

• We found that staff were highly motivated and regularly went the extra mile for people they supported. For example, on returning from a hospital stay, one person was unable to access their home due to damage following an incident. A staff member who had forged a positive working relationship took time out of their holiday to support them with liaising with emergency personnel and accessing their home to pack them a bag. The management team were able to support the person by working with social care professionals and other providers to find a suitable respite placement. The efforts made by the provider, in particular the staff member who worked closely with the person, enabled them to manage their conditions throughout a stressful period which could have been detrimental to them.

• Following our inspection, we were contacted by staff members who had been unable to speak with us on the day. One of them told us, "I'm very proud to be member of the team because of the way we all pull together, the continuous expectation of high-quality care to be offered to service users, and the support the staff receive from the registered and deputy managers and on call." A second staff member echoed these sentiments, staff were proud to work for a registered manager whose priority was to provide quality care to people.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• Systems were in place to audit the service and identify areas for improvement. Reviews with people and their relatives also fed into the providers quality reviews. For instance, positive feedback was given about a staff member during a review. The person told the registered manager they were extremely happy with the care delivered by one staff member, "It's the little things [care staff name] does. After they have gone I can go to the loo and there is always a spare toilet roll…the little things are really important."
• Audits were completed on a weekly, monthly and annual basis. Audits included care records, care plans, MAR's, accidents and incidents. At the end of the year the management team met to review the audits and completed an overall audit. This provided good oversight of service provision.
• The registered manager was a registered nurse and as part of their revalidation had to remain current with health and social care developments. Staff members each had continuing professional development record files in which to retain any evidence of new learning and coursework.
• The registered manager understood their responsibilities and ensured that the Care Quality Commission were notified about any significant events. Notifications contain information about events that providers are required by law to tell us about.
• The provider was clear as to their responsibilities under the duty of candour. The registered manager would inform relevant parties such as people, their relatives, local authority safeguarding teams and CQC should anything go wrong.
• The registered manager was committed to providing quality care to local people. They had also committed to ensuring that people they already supported would be offered additional care as it became available as a priority over adding new clients to the books. There was currently some shortfall in provision during the evenings and weekends. It was possible to cover all hours but any new packages requiring support at these times were signposted elsewhere. The provider was slowly growing their staff team, and this would enable new clients to be taken on.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Care plan reviews were held at least annually. If a person's care package changed there would be a review, or if there were any problems or the person or their family wanted to have a review.
• Staff meetings were held once or twice each year. Due to staff having other commitments when not working it was difficult to get the whole team together. The registered manager linked team meetings to team social events such as staff parties. This maximised the amount of staff who could attend.
• The provider issued an annual survey to ascertain if people and their relatives were happy with the care they received. The results of the survey indicated that people were very happy with services received and could recommend the provider.
• The registered manager was researching a different way to source feedback as they had found people reluctant to complete surveys. They had considered using online methods, seeking more qualitative feedback during care reviews or visiting people for a cup of tea and a chat. They also considered that mobile phone networks and broadband coverage in the area was poor so may limit the possibilities of online or

'app' based feedback. Initial plans included using symbols such as happy and sad faces and sending the questionnaire at different times of the year.
• A relative told us, "The manager is excellent and easy to talk to. I have been asked for feedback, but I don't really agree with that, so I am slow to follow it through, they are all good. I would recommend this agency to anyone else."
• A relative told us, "I feel very, very lucky and fortunate that this [service] exists in the village. That quality care is given to older people that isn't solely focussed on profit."

Working in partnership with others
• The provider had forged positive working relationships with other health and social care professionals and service providers locally. The local GP surgeries, district nurses, solicitors and businesses worked closely in the small community to support each other and people in need of care. The partnership working this achieved ensured that people's health and care needs were met seamlessly, communication was good and all involved parties were kept updated with changes in terms of people's needs and wishes.
• The provider worked with local authorities and care homes to support people in the next step of their care pathway. One relative told us, "It's very well managed, the manager has even contacted social services on our behalf and liaised with them for us about getting him into care, but it seems to be a long process. I would recommend this agency to anyone, they go well over what is expected and give us families peace of mind. We have no issues whatsoever with them, they are great."
• Work was being done to link more closely with local care homes so that training could be purchased jointly which was too costly for each individual provider. The close links also enabled the provider to take people who wanted to see care homes to services they were familiar with and could give information about.
• The registered manager and deputy manager were involved in local training and management initiatives. They were members of a national home care provider association, participated in local authority training and updates, were registered with a national training group, the county providers association and attended an outstanding managers group. The registered manager had also recently been part of forming a new group of outstanding service managers who were also registered nurses. Attendance of these groups ensured the provider was current with developments in care and legislation.