Making Space

Swallow Lodge

Inspection report

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Ratings

Overall rating for this service	**Good**
Is the service safe?	**Good**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection took place on 7 December 2015 and was unannounced.

Swallow Lodge is registered to provide accommodation and personal care for up to seven people who have a learning disability and some people also have a physical disability. There were five people present at the service on the day of our inspection; receiving either respite care or as an emergency placement until appropriate care services could be found.

There was not a registered manager in post at the time of our inspection. However, the acting manager had been in post five weeks and had commenced the application process to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect

Summary of findings

people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect them. The management and staff understood their responsibility and made appropriate referrals for assessment, no one living at the service at the time of our inspection had their freedom lawfully restricted under a DoLS authorisation.

People were kept safe because staff undertook appropriate risk assessments for all aspects of their care and care plans were developed to support people's individual needs. The acting manager ensured that there were sufficient numbers of staff to support people safely and this varied depending on the care needs of people, and the activities and outings that people were involved in.

There were safe recruitment processes in place and people were cared for by staff that had knowledge and skills to perform their roles and responsibilities and meet the unique needs of the people in their care.

People had their healthcare needs identified and were enabled to access healthcare professionals such as their psychologist and speech and language therapist.

People where able were supported to make decisions about their care and treatment and staff supported people to enhance their skills and improve their independence. People were treated with dignity and respect by kind, caring and compassionate staff.

People were treated as individual, and were supported to follow their hobbies and pastimes. People were involved in planning the menus and staff supported them to have a nutritious and balanced diet.

The registered provider did not have effective systems in place to monitor the quality of the service, such as regular audits.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People had their risk of harm assessed.

Staff were aware of safeguarding issues and knew how to raise concerns.

People's medicines were managed safely.

Good

Is the service effective?
The service was effective.

Staff had received appropriate training, and understood the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were cared for by staff that had the knowledge and skills to carry out their roles and responsibilities.

People were provided with a well-balanced and nutritious diet of their choice.

Good

Is the service caring?
The service was caring.

Staff cared for people in a person centred way.

People were cared for with dignity and respect.

Good

Is the service responsive?
The service was caring.

Staff cared for people in a person centred way.

People were cared for with dignity and respect.

Good

Is the service well-led?
The service was not always well-led.

The manager was approachable and respected by people, their relatives and staff.

The provider had not completed regular quality checks to help ensure that people received safe and appropriate care.

Requires improvement

Swallow Lodge

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.

The inspection took place on 7 December 2015 and was unannounced. The inspection team was made up of one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We used this information to help plan our inspection.

We looked at information we held about the provider. This included notifications which are events which happened in the service that the registered provider is required to tell us about. We used this information to help plan our inspection.

During our inspection we spoke with the acting manager, two members of care staff, four people who lived at the service, five relatives and a visiting healthcare professional. We also observed staff interacting with people in communal areas, providing care and support.

We looked at a range of records related to the running of and the quality of the service. This included two staff recruitment and induction files, staff training information, meeting minutes and arrangements for managing complaints. We looked at care plans for four people and medicine administration records for five people.

Good

Is the service safe?

Our findings

Staff were aware of safeguarding policies and procedures and knew how to recognise signs of abuse and what to do if they suspected that a person was at risk of abuse. One member of staff said, "I'd look for signs of mood changes or changes in their body language. I would report to the senior, if unavailable then the out of hours manager on call, they're always available." We saw that some people had been admitted to the service following incidents of abuse in the community. Staff had worked with the local safeguarding authority and allocated police officer to keep the person safe from further harm.

We saw examples of adaptions to the service to help keep people safe. For example some areas had heat reactive lights that came on automatically when a person entered the bathroom to help the person see what they were doing.

People had their risk of harm assessed for a range of activities inside and outside the service. People had care plans in place to support their assessed needs. For example, we saw that one person who was prone to falls from their bed had their risk of harm assessed and a care plan to support the actions staff would take to protect them. We also saw that risk assessments had been completed for a person who had a garden shed in the grounds with a heater and radio.

There were systems in place to support staff when the acting manager was not on duty. Staff had access to a contingency action plan to support them in an emergency situation such as a fire or flood and a local hospital had been identified as a place of safety to evacuate people to. Staff had access to on-call senior staff out of hours for support and guidance.

We looked at two staff personal files and saw that here were robust recruitment processes in place that identified all the necessary safety checks to be completed to ensure that a prospective staff member was suitable before they were appointed to post. Agency and voluntary staff underwent the same safety checks.

Staff told us that staffing levels changed depending on the individual needs of people living in the service at any given time. On senior member of staff said, "It's a bit of a balancing act. We always identify people with higher support needs on the duty rota and we care for them on a one to one basis."

There were processes in place for the ordering and supply of people's medicines to ensure they were received in a timely manner and out of date and unwanted medicines were returned to the pharmacist. We found that people on short term care brought their medicines with them and unused stock was sent home with them. Other people had their medicines prescribed by the local GP and further supplies were issued once month on a repeat prescription. A medicine tracking form was used to record all medicines in use and the current stock levels. Staff had the competencies to administer medicines and had attended medicine management training provided by the dispensing pharmacist.

People had their medicines stored in a locked medicine cabinet in their bedroom and a senior member of staff was responsible for the safe keeping of the keys. In addition medicines were administered in line with the provider's policies and procedures and staff had their competency to administer medicines checked by a senior member of staff.

We looked at the medicine administration records (MAR) charts for five people. We saw that all entries had been signed by two staff members. People's known allergies and special instructions had been clearly recorded on the front sheet. For example, one person was not permitted to drink orange and cranberry juice as it would cause a negative reaction with one of their medicines.

Good

Is the service effective?

Our findings

People and their relatives were positive about care staff and the care they had received. One person said, "Best place, people and staff in the world. Would recommend it to anyone. Made me well, healthy and happy." One person's relative said, "The staff are brilliant, really, really good."

In addition to mandatory training in key areas such as safeguarding, deprivation of liberty safeguards and health and safety; staff were provided with training that supported them to deliver person centred care based on best practice specific to the people in their care. For example, all staff were recently provided with a nationally recognised training course in behaviour management. The programme was tailored to meet the individual needs of the people and staff gained the skills to assess, prevent and manage unpredictable situations and behaviors. The overall aim of the course was to enable people to live a productive life. We saw evidence of the lessons staff had learnt and how this would be used on a daily basis. A member of staff said, "It was really, really helpful and will be really handy for any challenging situations. It answers how to stop things escalating to that level." Finally new staff had undertaken an induction and six month probationary period before they were signed off as competent to meet people's needs. The registered manager explained that there would be changes to the induction programme and new starters would undertake the new care certificate. This is a new training scheme supported by the government to give staff the skills needed to care for people.

We saw that people or their representatives gave their consent for care and treatment and for their photograph to be taken for identification purposes. A staff member said, "If we were unable to discuss consent with their parent or carers we would act in their best interest." Where a person lacked capacity to give their consent staff followed the principles of the Mental Capacity Act 2005 (MCA).

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We saw where people lacked capacity to consent to their care that their next of kin was a court appointed deputy. A court appointed deputy is someone appointed by the Court of Protection to make decisions on behalf of a person who is unable to do so themselves.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). There were no DoLS authorisations at the time of our inspection. The provider had properly trained and prepared their staff in understanding the requirements of the MCA and DoLS.

People were supported to eat a healthy, nutritious and balanced diet. In addition, people's special dietary needs and cultural preferences were respected and provided. Where a person was unable to take food and drink orally they received all their nutrition and hydration needs and medication through a special tube inserted directly in to their stomach. The person was supported by a dietician, community nurse and GP to manage this process effectively. Staff told us that they had been trained in the procedure by the person's relative and community nurse.

People told us that they enjoyed their meals and the food was good and staff involved people in planning their menus. One person said, "I help with the shopping list. We order on-line. I cook my favourites; spaghetti bolognaise, chilli and sweet and sour." We later saw this person being supervised to make their own lunch. In addition we saw guidance on preparing special diets and food choices such as gluten free meals and recipes to support sensible weight loss.

People were supported by a range of professionals relevant to their need, such as clinical psychologists, speech and language therapist and social worker. We found that staff worked closely with people's health and social care professionals to achieve positive outcomes for their health and wellbeing. Staff knew what to do when a person became unwell and the professionals to contact depending on the nature and severity of their health problem. One staff member said, "I'd make them a doctor's appointment and take them to see their GP, or if urgent dial 999 or call 111 for advice. Also their family would be informed at the

Good

Is the service effective?

first opportunity." One person's family confirmed that when their relative became unwell staff took appropriate action. They said, "He was poorly and they called 999 and called us in."

Good

Is the service caring?

Our findings

We spoke with one person who told us that their confidence, skills and wellbeing had improved so much that plans were in place to move into a place of their own. They said, “But I’m coming back to do voluntary work. To help people accessing the service. I’ll play with them.”

People and their relatives told us that people were well cared for. One person said, “We’re fine here, fine thanks. We all help with cleaning and the cooking is alright.” One relative spoke highly of the care their relative received and the bond they had with care staff and said, “We’ve used the service for a long time. [Name of person] comes every other weekend and stays for holidays. She is familiar with the place and staff know her well. They attend to all her needs. Had a shower last night and her hair washed. Has her own routine and gets up when she wants.” The relatives also told us that care staff always greeted the person when they arrived and helped make the transition from home smooth. Another family told us about the positive impact the service had on them and their relative’s well-being and said, “Came in as an emergency and they helped us out at a really bad time. We didn’t know we needed it [respite care] until we got it. He loves it. They take him on holiday.”

People were at the centre of the caring process and where able were involved in making decisions about all aspects of their care and environment. The service did not employ non-care staff. Staff enabled people to maintain their independence by supporting them in household tasks such as cooking, cleaning their bedrooms and doing their personal laundry. Furthermore, there was also a training kitchen where people were supported to develop independent living skills before moving into the community. We observed a staff member supervise one person to load the washing machine, add detergent and switch it on. There was good banter between them and the person was treated as a unique individual.

Staff had the skills to communicate with people sensitively and had attended training courses in non-verbal communication skills. We found that some people had complex needs and were unable to communicate their views and opinions verbally. We observed one person who used their eyes, facial expressions and hand gestures hold a conversation with care staff. We observed that care staff showed consideration and respect when person communicated with them. Staff used light hearted humour and the person responded positively to this.

When a person had complex decisions to make they were supported by an advocate. For example, we found that one person had an advocate appointed to support to them to make decisions about moving into supported living in the community and managing their finances. Advocates are people who are independent of the service and who support people to make their own decisions and communicate their wishes.

Staff were aware of the importance of maintaining a person's privacy and dignity. Before a person moved into the service staff asked them if they had a preference over male or female care staff supporting them with personal care. We found that when people went swimming that males were allocated a male member of staff and females a female member of staff. A staff member explained, “It means they have the same gender of staff for the changing room. We respect who they are.” Another member of staff said, “I help them change their clothes in the privacy of their own bedroom, and close the doors and tilt the blinds.”

Good

Is the service responsive?

Our findings

The service was purpose built and all bedrooms were spacious with their own bathrooms or access to a "Jack and Jill" bathroom shared with the bedroom next door. A Jack and Jill bathroom is a bathroom with two doors accessible from two bedrooms. Special equipment was in place to support people's individual needs. For example, hoists were fixed to an overhead track on the ceiling and people could be moved with ease from their bed to their wheelchair or in and out of the bath. In addition, we saw that there was a special shower trolley that also served as a shallow bath. We found that this contributed significantly to one person's daily routine as they liked to relax in the shower every day for an hour.

People were encouraged to bring personal items from home to give their bedroom a familiar look. We saw that some people on short term respite care had only brought a few basic items such as their radio, clothing and personal toiletries whereas others had made their bedroom homely with their music system, television and personal choice of bedding and soft furnishings. The relative of one person who received regular respite care said, "They always bring in something familiar from home, such as their babies [baby dolls]."

People had their care needs assessed by a social worker before they moved into the service and their personal care plans was developed to meet their individual needs. On admission to the service the person was allocated a key worker who in partnership with the person and their family recorded their likes and dislikes and developed their daily support plan and daily living skills with 24 hours. Relatives told us that they were involved in developing their plan. However, staff told us that when a person was admitted as an emergency it took longer to gather information about the person and complete their care plans.

Staff supported some people to learn new skills to enable them to live an independent life. For example one person had a voluntary job in a charity shop. They told us, "I've got a bus pass and the plan is that staff put me on the bus so as I can get used to going out on my own."

People and staff were preparing for Christmas and we saw Christmas trees and decoration had been put up around the service. One person told us with pride that they had decorated the Christmas trees. They said, "I have done the Christmas decorations." Another person showed us their bedroom and said, "It's nice and tidy. I've done the hoovering for Christmas."

Staff supported people to maintain contact with relatives and friends and maintain relationships with others who mattered to them. One person had a boyfriend and they told us that they were special to them and that the acting manager supported them to spend quality time together. However, we saw where one person's family were moving to another part of the country that the person was assessed at risk of social isolation and staff had put measures in place such as increased activity input to prevent this.

People were asked how they wanted to pass their time and what activities they would like to join in with. There was also a board where people could record their preferences. As a result some people had opted for a regular event called a "diversity disco." People met with like-minded people for a meal, music and games. However, the atmosphere was quieter than a "normal" disco and there were no flashing disco lights. Other regular events included evening visits once a week to a disco club and weekly afternoon visits to an indoor play park.

We found that people had a good quality of life and some told us that they always looked forward to the next big event. One person spoke excitedly about the Christmas party that was planned at a local sports and social club where they would meet up with friends from other services.

In addition to their bedroom, people had access to the dining room, a quiet lounge, a television lounge and the games room. The games room had a pool table and board games. One person said, "I like the [games] room, but I'd rather go to the pub, it's more fun. It's a nice place, but it's boring being in the same room."

The acting manager told us that due to the high turnover of people using the service, the activities provided frequently changed to reflect the needs and preferences of people using the service at that time. For example, an artist was visiting the service once a week as this was recently requested by people.

Some people were involved in a gardening club and we saw a wall hanger they had made displaying a variety of fruit and vegetables that they grown. We were shown the garden and saw that it was suitable for people of all

Good

Is the service responsive?

abilities. There were strawberry beds, herb beds and raised beds for vegetables that were a suitable height for a person dependent on a wheelchair to tend. One person's relatives spoke positively about the impact the garden had on their relative. They said, "It gives him a break, otherwise he would be home all the time. He likes the people here and learning quite a lot about the gardens." We saw that another person had a shed in the garden, where they made life size models and collages. The person could access their shed in any weather as it had a heater. The person also had their radio for company.

We found that when a person was ready to leave the service staff worked with their families, health and social care professionals and future carers to ensure a smooth transition from the service to the person's home, a permanent care home placement or independent living scheme.

The provider had a complaints procedure, with information for people and their families on how to raise their concerns. We saw that this was in easy read large print format with happy and sad faces to help people express how they felt.

On person's relative told us that they could talk to staff if they had any concerns and added, "Staff know what they are doing, I'm happy with that. We're involved with them, I have no issues, but I can ring and talk to them and they will listen." Another relative told us, "The staff are really down to earth we can talk to them about anything."

The provider had received three complaints in the previous 12 months and we saw that they had been fully investigated in a timely manner and the complainant had received a written response. Furthermore, we saw that staff had received written compliments for the care they had provided to people.

Requires improvement

Is the service well-led?

Our findings

We found weaknesses in the provider's approach to monitoring the quality of the service provided to people. For example, we looked at the results for the health and safety audit undertaken in November 2014. However, there was no recorded evidence that identified actions had been completed and improvements had been made to improve staff awareness or keep people safe. In addition, there were no systems in place to measure the impact other aspects of care had on people. For example, audits had not been undertaken for cleanliness and infection control, medicines and care plans.

There was not a registered manager in post at the time of our inspection. However, the acting manager had commenced the application process to become the registered manager.

Staff attended monthly team meetings and told us that they had a voice and were supported to speak out about the service and people who lived there. We read the minutes from the team meeting held the week before our inspection. Topics covered included; key worker roles, supervision in the kitchen and positive feedback from two families. Furthermore, the provider supported staff to raise any issues or problems through an anonymous whistleblowing service. A staff member said, "There is a number in the office at all times. It's an independent organisation that we can speak with."

The service had gone through a change of manager since it was registered a year ago. Staff spoke positively about the acting manager and told us that they were approachable, supportive and helpful when they needed advice. One staff member said, "[Acting manager's name] was on the same level as us and now he has been promoted he appreciates how hard our job can sometimes be. With [Acting manager's name] it's definitely settling down." Another staff member said, "We respect [Acting manager's name] for stepping up into this position. Their strategy is coming together and there is an air of excitement." We saw that the acting manager was visible, knew people's needs and preferences, had a good rapport with people and staff and was enthusiastic to drive the service forward. The acting manager was supported by the area manager.

The acting manager told us what incidents were notifiable to CQC as part of the provider's registration requirements, for example when there was serious injury or an incident. We saw that there had been three incidents reported in the last 12 months. However, there had been no serious injuries to report.

People and their relatives spoke highly of the standards of care in the service. We found that staff were supported to embrace the provider's vision to deliver high quality care that was innovative, responsive and flexible to people's needs and choices. Furthermore, the staff induction programme covered the core values of being person centred and working in partnership with people.

Staff received regular feedback on their performance and identified their strengths and weaknesses and areas for professional development through regular supervision sessions. The deputy manager told us that staff had not received an appraisal in the last 12 months, but they would now be introducing annual appraisals. One staff member explained how that their level of responsibility had increased through their supervision sessions and said, "At my November supervision I was given jobs to do with the care files. I feel supported."

There was a process were incidents, such as a medicine error were reported to the provider. A senior member of staff told us that incidents were discussed at team meetings, training needs were identified and lessons were learnt. We looked at recent safeguarding concern and saw that it had been fully investigated and the outcomes were shared with staff. Staff had access to policies and procedures on a range of topics relevant to their roles. For example, we saw policies on safeguarding, confidentiality and food safety.