Swanton Care & Community Limited

Swanton Community Care

Inspection report

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Tel: 07786551827

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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

Summary of findings

Overall summary

Swanton Community Care supports people who are living with a learning disability to live as independently as possible within their own homes. The main office is located on an industrial site close to Hessle Road in Hull and has accessible entrances and car parking facilities. The team supports people in Hull and East Riding of Yorkshire. Currently personal care is provided on a 24 hour basis to five people who live at the same address and one person who lives on their own with staff support.

The service is required to have a registered manager by a condition of registration. 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 legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had recently left the service and recruitment was underway. There were measures in place for a locality manager to oversee the service and a service co-ordinator managed the day to day operation.

We undertook this inspection on the 9 August 2016. We gave the service 24 hours' notice as we wanted to be sure there was someone available at the main office to speak with us.

Is the service safe?
We found staff were recruited safely and there were sufficient staff employed to meet people's care needs. Some people who used the service were assessed as requiring one to one support and staff confirmed they always had this support. We found staff had received training in how to safeguard people from the risk of harm and abuse. They were knowledgeable about what constituted abuse and what to do should they become aware it had happened. Staff completed risk assessments for specific areas to help identify risk and also to help reduce it without overly controlling people's lives. We found people received their medicines as prescribed. Staff had received training and managed medicines safely.

Is the service effective?
We found staff supported people who used the service to meet their health care needs and to access health care professionals when required. They supported people to make appointments and accompanied them to the doctors or dentist. People's nutritional needs were met. Staff supported people to shop and prepare their meals. They provided advice to people when required about healthy eating. Staff supported people to make their own decisions and choices about aspects of their lives. Some people lacked capacity and when this occurred, staff knew what action to take and how to apply legislation to ensure decisions were made in their best interest. Staff involved relevant people when best interest decisions were made. We found staff had access to a range of training which was considered essential to their roles and which was specific to the needs of people who used the service. The training, support and appraisal system helped staff to feel confident when supporting people. The building where the service was located had an entrance suitable for people who used wheelchairs or who had mobility difficulties.

Is the service caring?
We observed staff supported people in a kind and patient way. They had developed positive relationships with the people who used the service and knew their needs well. We observed staff respected people's privacy and dignity and helped them to develop independent living skills. Staff helped people to keep in contact with their friends and family. Information and explanations were provided to people, some of which was in an easy read format. We saw staff held people's personal records securely and maintained confidentiality.

Is the service responsive?
We found people who used the service had an assessment of their needs and care plans were developed which guided staff in how to support them so care was not overlooked. Staff were responsive to people's changing needs and kept documentation up to date. There was information in assessments and care plans about people's preferences for care, what was important to them and how best to support them. This helped staff to deliver care that was centred on the person. Staff supported people to participate in activities of their choice and to feel part of the community by accessing local facilities. There was a complaints policy and procedure in easy read and people spoken to felt able to complain knowing it would be addressed.

Is the service well-led?
The registered provider had failed to submit notifications to the CQC about some incidents which affected the health and welfare of people who used the service. This is a requirement of registration with the CQC. We use this important information to assess how the provider manages incidents to help prevent re-occurrence of them. This helps improve the safety of the service for people who receive care and support. We have written to the registered provider on this occasion reminding them of the need to send in notifications in line with our regulations. We found the culture of the organisation was open, transparent, inclusive and focussed on putting people who used service first; people felt able to raise concerns and staff felt listened to. There was a quality assurance system which made checks on a range of areas and ensured that any shortfalls were identified and addressed.

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.

Staff knew how to keep people safe from the risk of harm and abuse. They completed risk assessments and supported people to minimise risk whilst ensuring they maintained some control of their lives.

Pre employment recruitment checks were in place to help ensure sufficient staff, of suitable character, were employed to work with vulnerable people and meet their needs.

Management of medicines was safe and people received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

People's health care needs were monitored and staff supported them to access health care professionals when required.

People's nutritional needs were met and staff provided guidance and advice in choosing health options.

People were supported to make their own decisions. When people lacked capacity, the registered provider acted within the law and ensured decisions were made in their best interest.

Staff had access to training, supervision and appraisal which provided them with the skills, knowledge, support and confidence they required to care for people.

Is the service caring?

Good

The service was caring.

Staff were observed speaking to people in a kind and patient way and treated them with dignity. Staff respected people's right to privacy.

People were provided with information and explanations so they

could make informed choices and decisions about aspects of their lives.

Confidentiality was maintained and personal information stored securely.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and plans of care developed to guide staff in how to meet them. People had been involved in their assessments and care plans and they had provided information about preferences for how care was to be delivered to them. This enabled the care provided to be person-centred.

Staff supported people to participate in activities of their choice and to access community facilities.

There was a complaints process and people and their relatives felt able to tell management of any concerns so they could be addressed.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The Care Quality Commission (CQC) had not always been notified of incidents which affected the safety and wellbeing of people who used the service. We have written to the registered provider to remind them of the need to send CQC notifications.

There was a quality assurance system which enabled checks to be made, shortfalls to be identified, action plans to be made to address them and learning to take place.

People were asked for their views in order to help improve the service.

Swanton Community Care

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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 9 August 2016. We gave the service 24 hours' notice as we wanted to be sure there was someone available at the main office to speak with us. The inspection team consisted of one adult social care inspector.

Prior to the inspection, the registered provider had completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also checked our systems for any notifications that had been sent in as these would tell us how the registered provider managed incidents and accidents that affected the welfare of people who used the service.

Prior to the inspection we spoke with local authority contracts and commissioning teams about their views of the service and received information from two social workers.

During the inspection, we spoke with three people who used the service and three of their relatives. We observed how staff interacted with people who used the service and how staff administered medicines to them. We spoke with the locality manager, the service co-ordinator, a team leader and a support worker.

We looked at three care files which belonged to people who used the service. We also looked at other important documentation relating to people who used the service such as two people's medication administration records (MARs), accidents and incidents, and management plans for people with diabetes and epilepsy. We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These

included three staff recruitment files, training records, the staff rota, quality assurance audits, complaints management and maintenance of equipment records.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe with the staff team when they supported them. Comments included, "Yes I do [feel safe]", "They [staff] are not bossy" and "Yes, I'm very happy here and I do feel safe actually; I get along with [names of people who use the service]."

Relatives told us the people who used the service were supported well and cared for by the staff team. Comments included, "It's a very good level of care. All the staff are brilliant", "Yes, everything is fine" and "She is very happy there. She is not on medication now as it has been slowly withdrawn."

We found there was a policy and procedure to guide staff in safeguarding people who used the service from abuse and harm. Staff received training and were able to discuss the different types of abuse and the signs and symptoms which may alert them abuse or poor practice had occurred. Staff knew how to respond if they witnessed abuse or poor practice. Staff said, "Report it and document it. If it is between service users, then we have to make them both safe. We'd report to social services and the duty officer if out of hours" and "I am very confident people are not being abused; we have a good staff team with wide knowledge and expertise." Staff were aware of the registered provider's whistle blowers policy and procedure; there was also a whistle blowers helpline for advice.

Staff had completed assessments of risks to people who used the service that were associated with their daily living activities. These included areas such as, accessing the community either alone or with staff, changing behaviour patterns, self-medication, mental health, and health conditions which affected people such as epilepsy and diabetes management. Included in people's care files were any risk assessments or management plans completed by health professionals involved in their care and support.

We found people received their medicines as prescribed. Staff had received training in how to administer medicines to people and they liaised with health professionals when required. We visited five people in their own home, which was shared accommodation and we saw their medicines were stored appropriately and securely. Staff recorded when they administered medicines to people and had supervision arrangements in place when people administered their own medicines. We observed a member of staff administer people's medicines, which was done patiently and appropriately; however, information regarding how one person preferred to have their medicines and how they made their pain needs known could be recorded and held with their medication administration record (MAR) to ensure there was written information for staff. We saw management plans for people who had epilepsy and diabetes were held with their MARs so they were easily accessed when required. In discussions, it was clear staff had a good understanding of these plans and followed them accurately. There was a system in place that was effective in ensuring people did not run out of their medicines.

Staff rotas indicated there were sufficient staff on duty to support people's current level of needs. Some people had additional hours on a one to one basis to support with specific activities; these were commissioned by health or social services and we saw this was highlighted on the staff rotas. Staff confirmed they felt there was sufficient of them to support people and also confirmed one to one hours

were completed. Comments included, "We have run a bit short in the past two weeks due to the holiday season but usually it's fine; we use bank [occasional staff who have been recruited in the same way] staff and increase staff hours" and "Everyone [people who used the service] always has their one to one time."

There was a recruitment system which ensured checks were in place prior of new staff starting employment. These included an application form so gaps in employment could be assessed, two references and a check with the disclosure and barring service (DBS). DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. Potential new staff also attended for an interview so their knowledge could be tested. These measures helped to make sure staff were suitable to work in the care industry.

We spoke to the locality manager about business continuity arrangements should there be a failure in utilities or flooding on the office base. They showed us a policy and procedure for this and told us the business could be temporarily managed from another location, and as all records were held electronically, business would not be interrupted. The registered provider was currently assessing a new computerised communication system which was due to start in September 2016. This consisted of portable hand held equipment for staff which could communicate their shift patterns, their logging in and out of people's homes and also include support plans for the people they supported.

Good

Is the service effective?

Our findings

People who used the service told us staff knew how to support them and helped them to eat healthily and to access health professionals when required. Comments from people included, "They help with tablets and tell me if I need any extra", "I have my own key and come and go when I want. I like ready meals and have all sorts to eat; now and again I'll shop and cook", "I do things when I want; I change my mind a lot", "Staff go with me to the doctors. Since I first came here, I couldn't do things for myself; I'm learning so much from the staff, I can do things now" and "I'm cooking things from scratch and I'm very pleased I've lost weight."

Relatives told us staff were supporting people to gain skills, increase their independence and access health professionals when required. They said, "They are working towards independence and [person] goes down to the day centre on their own; there's a plan in place for this", "Staff support [person] to access health professionals", "They have definitely increased their independence", "They try their best to increase independence skills", "They don't leave things to chance and they get the GP quickly" and "[Person] has a good diet; they were underweight when they went there and within a few weeks had put on 10lbs. They make sure [person] gets fruit and vegetables."

We received comments from two social care professionals involved in people's support. They said, "[Person] requires support to arrange medical appointments but generally goes on their own to them. They are quick to pick up any changes to their mental health state and report this to the nominated health professional. They monitor diabetes", and "Overall, the service has been really positive for this service user."

We found people were supported to access health professionals when required. In discussions, staff described how they would deal with medical emergencies, for example an epileptic seizure, and how they recognised when people were unwell. They told us they would always pass on information to the parents of the people they supported and to health care professionals. It was clear from discussions that the staff team knew people's needs well. Staff said, "Yesterday [person] was complaining of ear pain so we took them to their GP; they have an ear infection and have got antibiotics", "[Person] would tell us if they were unwell" and "[Person] can't tell us when they feel unwell so we go by their behaviour; if they are unwell they don't want to get up and can become more vocal so we test their urine in case it's an infection." Staff went on to describe people's health needs and the signs and symptoms that would indicate they were unwell or becoming anxious and what action they would take.

We saw people were supported to eat a diet of their choice. One person had told staff they wanted to lose weight and staff had supported them to achieve their goal. Staff told us there used to be planned menus but this system had changed. They said, "Two people have planned menus but other's choose what they want to eat on the day", "The service users have meals at different times of the day and one person has diabetic meals and another person is on a reducing diet of their own choice; they have done really well and staff are encouraging them", "[Person] has large portions and they are able to feed themselves but they have a tendency to drop some of the food so the portion size makes up for it" and "We ask people what they would like to eat, sometimes it can be trial and error." Staff documented what food and fluids people ate and drank and monitored their weight so that fluctuations could be addressed with appropriate health

professionals.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. When people live in the community, applications must be made to the Court of Protection for this. The registered manager was aware of this and there had been discussions with the local authority on whether applications to the Court of Protection for three people who used the service were required; this process was still underway.

We found the registered provider was working within the principles of the MCA. Some people who used the service had full capacity to make their own decisions and had contracts and tenancy agreements they were able to understand and agree to. Staff understood that people who lacked capacity to make major decisions would need a best interest meeting with relevant people such as relatives and health and social care professionals involved in their care to assist in making decisions on their behalf. They also understood that people who lacked capacity for major decisions were still able to make day to day decisions about their care. Staff had completed MCA training and described how they assisted people to make their own choices. They said, "We are aware of who has full or partial capacity and whose family have Court of Protection", "Each person has their own plan and they make their own choices" and "[Person] is very independent and goes out alone."

In our discussions, staff confirmed they completed training prior to supporting people and then had refresher training when required. Records indicated staff had completed a range of courses and these were confirmed in discussions with staff. The training included first aid, moving and handling, infection prevention and control, fire awareness, basic food hygiene, dignity and human rights, information security, safeguarding adults from abuse, health and safety, MCA, Deprivation of Liberty safeguards, medicines management and the philosophy of the organisation. Other training included conditions which affected the people who used the service and included, autism, diabetes and epilepsy management. Staff had also completed 'positive behaviour support and working with behaviours that challenge' and 'restrictive interventions', two courses accredited with the British Institute for Learning Disability (BILD).

All staff had completed the Care certificate which provided them with a comprehensive introduction to caring for people. Staff told us there was a range of methods used for training. These included, face to face sessions, work books and on-line computer based training. Some staff had achieved a nationally recognised qualification in health and social care and a team leader we spoke with told us they were progressing through a level five management and leadership course. We saw from training records that an analysis had been completed regarding gaps in training, for example, not all staff had completed training in the conditions affecting people who used the service. This had been highlighted so courses could be arranged. Staff said, "Yes, we get enough training and we can always ask if we want any more."

Staff confirmed they felt supported and had supervision meetings where issues such as training, what works well with the people who used the service, any issues they had or any ideas they wanted to share. Staff said, "We have good support when we need it" and "We have discussions and supervisions and we are able to voice opinions."

The locality manager described the induction process for new members of staff. Currently, this was arranged over a two week period but they said there were plans to expand this to four weeks. The induction included

a range of essential training, an introduction to the philosophy and values of the organisation, shadowing more experienced staff and a mentoring system. There were also monthly progress meetings during the three-month probationary period which could be extended if required. The locality manager said, "We link up staff with service users, look at the dynamics and skills of staff and do a matching exercise of personalities. There are one page profiles for service users and we are thinking of doing these for staff as well."

We saw the premises were suitable as a domiciliary care service. The service was located within an office building and had access to reception staff from 09:00 to 17:30. There was also the facility for the receptionist to take calls and pass messages onto office staff should they be out in the community or in meetings. The company who owned the building was responsible for maintenance, fire safety checks and security; there was a key fob system to enter and exit, an alarm and secure parking. The service had access to one office, which had two desks, appropriate office equipment and secure cabinets for staff personnel files and documentation for people who used the service. There was a kitchenette, toilet facilities, a meeting room which could be booked when required and access for people who used wheelchairs or who had mobility difficulties.

Good

Is the service caring?

Our findings

People we spoke with told us staff treated them with kindness and patience. They said staff respected their privacy and dignity and ensured they made their own decisions. It was clear people who used the service knew all the first names of the staff. Comments included, "I like it here. [People] talk loud", "Yes, I get up and go to bed when I want", "I'm happy here and the staff are lovely actually" and "I do things for myself; I have freedom."

Relatives of people who used the service were complimentary about the staff team. They said, "The staff are helpful and friendly; they give me a ring", "She likes most of the staff especially the younger ones; [member of staff's name] in particular takes her to buy clothes", "I can't praise the staff enough; I have no worries there. One member of staff went to Beverley Hospital for medication one night in their own car", "I think there is a very good level of care; all the staff are brilliant and they all know her well", "It's a nice atmosphere [in the house that people whom use the service share]", "Yes, definitely [promote privacy and dignity]; all the staff are good with that", "I've not met too many of them [staff] but those I have met have been lovely" and "We wanted a home environment for [Person] and they [staff] are getting to know them."

Social care professionals said, "[Person] has a good relationship with the care staff and finds them easy to approach" and "Staff support [Person] around developing their independence in terms of managing their own personal care, support with food shopping and meal preparation."

We met some of the people who used the service and took the opportunity to observe how staff interacted with them. We saw positive relationships had been developed between staff and people who used the service. We observed staff spoke to people in a kind, patient and caring way. They provided information to people, offered them choices, ensured they made their own decisions and engaged in friendly conversation with them.

We saw staff supported people to be as independent as possible and encouraged them to do as much as they were able themselves. For example, we saw people were encouraged to participate in household tasks when they were able, such as shop, prepare meals, wash up, complete their laundry and tidy their bedrooms. One person had a plan to support them to be independent and safe when accessing the community. In discussions, staff described how they respected people's privacy and dignity and promoted choice and independence. The locality manager told us they cared for the people who used the service but 'not in a mothering way'. They said, "Staff go the extra mile and I'd be proud to have the staff support my relative."

We saw care plans contained information about how people communicated their needs and what level of support they required from staff. Each person's care file included preferences for how they wished staff to support them. The information described what people could do for themselves and staff recorded what the achievements they had made. For example, one person had information about how well they were progressing with spelling and that they had been able, for the first time, to order a cup of tea in a café and pay independently.

We saw people who used the service were provided with information, such as a tenancy agreement and on a day to day basis they were provided with options to help them make choices about the meals they wanted to eat. Each person was provided with a weekly planner of activities for daily living and leisure pursuits. The information provided to people was in a simple format to make it easy to understand. We saw the parents of people who used the service were very involved in their relatives care and support and were included in decisions made about them. Meetings were held to discuss issues and day to day contact was made with parents when required.

The locality manager, care co-ordinator and staff team were aware of the need to maintain confidentiality and to keep personal information secure. Information regarding people who used the service was held securely in lockable cabinets in the main office; there were also documents such as care plans and medication administration records within people's own home. These were held securely but were accessible to people if they wanted to see their own records. We saw computers at the location were password protected to make them inaccessible to unauthorised people. The registered provider was registered with the Information Commissioners Office (ICO) which was a requirement when computerised records were held.

Good

Is the service responsive?

Our findings

People we spoke with told us staff supported them to access the community and to participate in leisure pursuits. They also said they would tell staff if they were unhappy with anything. Comments included, "I have my own key and go out on my own", "Staff go with me to Costa Coffee and I put music on", "On Wednesday, I'm doing the legacy games at a local school and mum picks me up to go out" and "I'd tell the staff if I had any complaints." One person told us they had been to Beverley, to the York Dungeon and to local parks. They said, "Me and [Staff's name] have a right laugh; we're going swimming on Monday."

Relatives told us they had been involved in assessments and formulating care plans. They said they were kept informed and were invited to meetings. They confirmed staff supported their family member to access the community. They also said they would feel able to raise concerns and knew these would be addressed. Comments included, "They involve me in assessments and care plan meetings", "I had a letter telling me about management changes", "We have been involved every step of the way; they have been really understanding and supportive of our situation", "In warm weather, its almost empty as they all get out and about", "Yes, I would feel able to raise a complaint but there are no serious complaints; anything that is brought up is looked into" and "I've never had to mention any concerns."

Social care professionals told us they had seen care plans and assessments and these were kept up to date. They also said people were supported in an individual way. Comments included, "On the visit I made, all support plans and risk assessments were up to date", "Risk assessments have been up to date at previous review meetings" and "The service user seems to have a clear structure to their days which works well and staff support them around developing their meal preparation. I feel staff I have worked with are very pragmatic in their approach to service users and support individual's care needs in a person-centred way."

We saw people's needs were assessed and identified prior to the start of the service. There was information from health and social care professionals involved in the person's care. The documentation completed by staff described what new staff would need to know 'at a glance' and this was held at the front of each person's care file. Risk assessments indicated areas staff needed to be particularly aware of and what measures they needed to take to help reduce the risks whilst assuring people were able to make decisions. These included the risk of physical and verbal behaviour which could be challenging to the person and others, the home environment, accessing the community, potential vulnerability when outside alone, keeping safe when travelling in cars and on buses, and health conditions that could pose a risk such as epilepsy and diabetes. The locality manager described how one person, who liked to go out alone had a system of letting staff know his approximate return time and carried a mobile phone in case of emergencies. The risk assessments and measures to reduce risk help care to be centred on the person. We found some risk assessments could include more information about control measures and mentioned this to the locality manager and care co-ordinator to address.

We saw staff completed 'hospital passports' which were used to provide information to medical and nursing staff should the person be admitted to hospital for treatment. There were other occasions when staff worked with agencies to support people when care was transferred from one agency to another. For

example, we saw one person had a transition plan when they were first introduced to a house they were to share with other people. This included visiting with their social worker, meeting people they would be sharing a house with, meeting their keyworker and other members of staff who provided a service, staying for meals and eventually having an overnight stay to see if they liked living there. Staff documented their support throughout this transition period so they could keep health and social care professionals, who were involved in supporting the person, aware of their progress.

Information we looked at described people's individual needs and preferences and we saw people who used the service received person-centred care. The care files contained information about what was important to the person and how best staff were to support them. For example, there were 'about me' documents which included 'my past', 'important people and pets', good things about me', things that are important to me', things I do not like' and 'in the future'. The information covered how people communicated their needs, everyday choices, their physical health needs, preferences for rising and retiring and their daily routines. There was information about what the person could do for themselves and what support was required from staff in specific tasks. For example, in making snacks, preparing drinks, tidying up their bedroom, completing laundry, using the telephone and computers, shopping, developing and maintaining social relationships and friendships, managing money and pursuing hobbies and interests.

We saw people had specific health care plans which detailed their needs and how these were to be met and which health care professionals were involved in supporting them. Some of the care plans, for example for those people with diabetes and epilepsy, the care plans were produced by health care professionals and included in their care files. Staff spoken with were aware of these health care plans.

We saw staff had been responsive to people's changing needs. For example, one person had found it difficult living in a particular house and required more space so they could spend time alone and eat their meals on a one to one basis with staff. Staff had supported the person to look at alternative accommodation and a new service was in the process of being set up which would more effectively meet their needs. The person told us about the move to a new house and said they were happy about this. We saw a record of a meeting between the person and staff; the move to a new house was discussed and what the person thought and felt about it.

Staff developed care plans and helped people set goals. They recorded when achievements were made so people felt a sense of worth. We saw staff had supported people to decorate and personalise their bedrooms in their home. We saw records of reviews of people's care and staff documented when they had meetings with them to discuss how support was going.

We saw people were supported to participate in activities of their choice and to access community facilities to help social inclusion. Each person had an individual plan which was subject to change to accommodate choices. Some people had one to one staff allocated for a specific number of hours per week to support with activities. The activities included shopping for food and personal items, attending appointments and day centres, swimming, walking, attending football matches and accessing cafes and local pubs. One person attends college, one person attends trampoline sessions and staff are sourcing horse riding for one person. There were also activities that staff supported with in-house such as cleaning their bedrooms, watching television and DVDs, listening to music, chatting to staff and each other and playing games. There was a games room for people to use in their house. We saw people were supported to keep in touch with their relatives, meeting them and making phone calls.

There was a complaints policy and procedure. This described how people could make a complaint and how

to escalate it if required. People who used the service were provided with a copy of the complaints procedure in their home. The complaints procedure was supplied to people in easy read format. Staff spoken with were clear about how to manage complaints.

Requires Improvement

Is the service well-led?

Our findings

During the preparation for the inspection, we checked our system for notifications of incidents which affected the safety and welfare of people who used the service. When cross-referenced with the recorded incidents which had occurred between people who used the service, we found we had not been notified about some of them. Some of these were incidents which had occurred between people who used the service and on some occasions when minor physical interventions had been required. The locality manager told us this had been an error and in future the Care Quality Commission (CQC) will be notified of all incidents when they occur at the same time as notifying the local safeguarding team. It is important we receive notifications for these incidents so we can monitor the amount of them and check with the staff how they are addressing them.

Not notifying us of incidents which affect the safety and welfare of people who use the service is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. On this occasion we have written to the registered provider reminding them of their responsibility regarding notifications to CQC.

People who used the service told us they had been informed of changes in management and were able to tell us the name of the care co-ordinator who was managing the service on a day to day basis and also the team leader who worked within the shared house they lived in.

The relatives of people who used the service were aware of the management team and told us they were able to contact them if they had any concerns. One relative raised an issue regarding repairs to the building where their family member lived; they said these took a long time to fix and one issue wasn't fully resolved. This was mentioned to the locality manager to address with the landlords.

A social care professional told us they had no issues with the care provided to people from staff but they felt communication between staff and between staff and visiting professionals could be improved. They said, "At times I feel there is a significant lack of communication not only between care staff and myself but also between care workers. Some messages I have passed on to certain staff don't seem to have been circulated." This was mentioned to the locality manager to address with staff.

There was no registered manager at the service and the locality manager told us recruitment was underway. It is a requirement for a registered manager to be in post as this adds stability to services. There was a management structure in place in the interim, which consisted of a care co-ordinator for day to day issues and the locality manager. However, this was to be short term only as the locality manage was due to leave in the next week. The locality manager told us an area manager would be providing oversight for the service and support to the care coordinator until the new manager is in post. The care co-ordinator told us they felt very well-supported and had avenues of support should they be required.

We found the structure of the organisation consisted of a Chief Executive Officer and tiers of directors and managers; this provided a structure of oversight and support to staff who worked with people who used the service. There was a statement of purpose which described the culture of the organisation, its values,

purpose and goals and the method by which these would be achieved. The focus was on individualised support, empowering people who use services, training staff and working in partnership. We saw posters and cards which described the philosophy of the service. Staff received training in this so they knew what was expected of them. The philosophy described the expectations of staff and behaviour of the organisation as a whole, and included beliefs, and the desired experience and outcomes for people who used the service. We found this philosophy was demonstrated in practice during our observations of staff interactions and support for people. The organisation was a Health Investor Awards winner in 2016 in the complex care provider of the year section. This award is an annual celebration of those who invest in, advise, lend to and operate, in the health and social care markets. The award helps to improve quality for people who used the service.

Staff were provided with a handbook which provided them with information such as personnel issues and a short version of policies and procedures, for example whistle blowing. The locality manager and care co-ordinator discussed the culture of the organisation and said it was open and enabling. They said, "It's about enabling people to have as full and independent life as possible. People are treated equally despite any disability."

Staff told us they liked working for the organisation and felt supported by management. We saw minutes of various staff meetings which documented the issues they discussed and their opinions. The locality manager said, "We have manager's meetings monthly", "The staff work well as a team" and "Staff contribute to development plans within the organisation." Staff said, "There is always someone on call" and "We can always contact the area manager [Name]. We have email addresses and phone numbers."

The locality manager described how rotas were changed as a result of listening to staff. We saw staff were able to access the CEO via tea and talk chats and there was a whistle blowers helpline for staff to use if required. Staff were kept informed about news within the organisation via a newsletter. The locality manager told us about incentive schemes to recognise achievement, to help retain staff and at times just to say 'thank you' to them. There was a shop discount scheme for staff, pay incentives, refer a friend [for employment], support to study and development of staff, for example team leaders completed level five courses in management. Each month a member of staff was 'recognised' for their work and received a letter of thanks from the CEO. We saw the Swanton Newsletter for May 2016, which had information about a competition to provide a name for the staff incentive scheme.

We saw there was an annual quality monitoring system that consisted of a range of audits, discussions with people who used the service to seek their views, observations of staff practice and surveys. The locality manager showed us an operations report for July 2016 (these are completed monthly) which included areas such as personnel issues, referrals to the service, incidents and accidents and audits that have been completed. We also saw an incident/accident log for July 2016 which detailed who had been involved in the incident, what action staff had taken, what measures had been put in place to prevent re-occurrence and what learning had taken place. We saw the information from the quality checks was submitted to the registered provider's governance and quality team each month and collated in a 'governance and quality report'. The report highlighted key performance indicators in a range of issues such as safeguarding and management of people's changing behaviours, staff training, complaints management and audit schedules. The report showed us senior management had oversight of quality issues in order to direct additional support to teams and locations when required.

The locality manager also described a system whereby some people who used the service go to other locations within the organisation and are supported to assess quality and feedback their findings to the governance and quality team who then produce an action plan. They said, "This is one of the ways we listen

to service users."