

Swanton Care & Community Limited

Swanton House Care Centre

Inspection report

Dereham Road
Swanton Novers
Norfolk
NR24 2QT

Tel: 01263860226
Website: www.swantoncare.com

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service: Swanton House Care is a residential care home that was providing personal and nursing care to 30 people living with a mental health condition and/or learning disability at the time of the inspection.

People's experience of using this service:

The service has a history of poor governance. At this inspection improvements had been made in the leadership however there remained areas of concern in the management of the service.

Audits were still not sufficiently robust to identify all areas for improvement and to identify and manage risks.

The culture within the organisation had become much more positive and staff felt supported and said that they enjoyed their jobs.

People and staff were engaged in the ongoing development of the service.

Individual risks relating to people's care and support were not always identified and managed safely.

Incidents and accidents were not always reviewed to prevent things from happening in the future.

There were not always sufficient numbers of staff to support people and meet their needs.

Medicines were being managed safely in the home.

Staff understood how to prevent and control the spread of infection.

The policies and systems in the service did not support people to have maximum choice and control of their lives.

People's care needs were holistically assessed, and staff had the appropriate training to enable them to meet people's needs.

People were supported to eat and drink. The cook was knowledgeable about people's diets and special needs with regard to food and nutrition.

The service worked well with other professionals to meet people's healthcare needs.

There was an ongoing programme of improvement to the premises. We have made a recommendation about the decoration of the premises where people with visual impairments live.

People were not always cared for in a timely way. In Holly unit people often had to wait for their care. The service had an activity programme in place which had been put in place since the last inspection and was tailored to meet people's needs. However, there was further development needed in order to engage people who spent time in their room.

The service had plans to introduce training in End of Life Care for staff and had started to record peoples wishes for the future.

Rating at last inspection: The service was rated requires improvement at the last inspection. (Report published May 2018). At that inspection we found breaches of regulations 9, 10, 12, 17, 18. At this inspection we found some improvement had made. The service was no longer in breach of regulations 9 and 10, but was still in breach of regulations 12, 17 and 18 and had an additional breach of regulation 11.

Why we inspected: This was a planned inspection based on the rating at the last inspection.

Enforcement:

Follow up: We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve the rating of the service to at least Good. We will require them to provide an action plan detailing how this will be achieved. We will revisit the service in the future to check if improvements have been made.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk.

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 not always safe

Details are in our Safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective

Details are in our Effective findings below.

Requires Improvement ●

Is the service caring?

The service was not always caring

Details are in our Caring findings below.

Requires Improvement ●

Is the service responsive?

The service was not always responsive

Details are in our Responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not well-led

Details are in our Well-Led findings below.

Inadequate ●

Swanton House Care Centre

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:

The inspection was carried out by two inspectors, a pharmacy inspector and an expert by experience. An expert by experience is someone who has personal experience or using or caring for someone who uses this type of care service.

Service and service type:

Swanton House Care is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home is registered to accommodate 49 people for residential and nursing care. People may have a mental health need, a learning disability, a physical disability or a dual diagnosis. Some people are living with dementia. The service accommodates people both over and under 65. People currently live in two separate houses called Holly and Bluebell. These are single-story purpose-built houses with some self-contained accommodation. The third house, Birch, is a converted period building. There was a plan to refurbish and modernise the accommodation in this building. At the time of inspection, it was only used for office space and communal activities.

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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: The first day of inspection was unannounced. The second day was announced.

What we did:

Before the inspection: We reviewed the information, we had received about the service since the last inspection. This included information from statutory notifications. Statutory notifications include information about important events which the provider is required to send us by law. We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also sought feedback from the local authority and professionals who work with the service.

During the inspection: We spoke to eight staff including a nurse, two team leaders, the cook and an activities worker. We spoke to six people who used the service and one relative. We reviewed ten people's care records. We looked at the medicine administration records (MAR) and supporting documents for ten people. We looked at records relating to the governance and management of the service. After the inspection we asked the registered manager and service manager to send us further documents which we received and reviewed.

Is the service safe?

Our findings

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

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Systems and processes to safeguard people from the risk of abuse

- At our inspection in June 2017 we found that risks to people were not managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider remained in breach of the regulation at our subsequent inspections in January 2018 and May 2018.
- At this inspection we continued to have concerns about the management of risks.
- Individual risks to people and others were not managed and mitigated sufficiently. Significant risks had not been assessed and there was no guidance for staff on how to manage these risks. Where people had a history of inappropriate behaviour details of this was not included in their risk assessments.
- There were support plans in place to manage some risks for some people. However not all staff were following the support plan which meant that the risk was not managed.
- Risk assessments had not been carried out in relation to risks people might present to staff. Where gender of the carer may affect the level of risk this was not fully explored to safeguard staff.
- There was no consideration or risk assessment around whether chemicals or toiletries should be stored securely for the safety of a person who may have been at risk of ingesting these liquids.
- When we reviewed the records of incidents and accidents we found that not all records had been reviewed by the registered manager and not all records had actions noted to prevent incidents from reoccurring in the future. This meant that the provider could not be reassured that people were safeguarded, and lessons were not always learned, and necessary actions taken to prevent reoccurrence.
- For example, we found an incident report relating to a time when a person used their call bell to call staff when another service user had entered their room undressed. The manager told us that there was a support plan in place to prevent incidents like this happening, and the room doors were alarmed to alert staff so that they attended calls as soon as possible. However there had been no investigation as to what had happened on this occasion. On the day of our inspection staff told us that the alarms on people's rooms were not always switched on. This meant that they would not alert staff to incidents such as this.

The failure to ensure risks relating to the safety and welfare of people using the service had been assessed and managed was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- After our first day of inspection we brought our concerns to the attention of the registered manager and when we returned for the second day we found that risk assessments had been put in place to manage the risks.
- Risks had been assessed in regard of certain aspects of care. For example, people's risk of pressure ulcers,

moving and handling and risk of malnutrition were all assessed.

- Staff were aware of managing risks in the areas that had been assessed and could describe how they mitigated these risks. For example, by repositioning people at risk of pressure ulcers.
- People told us they felt safe. One person told us, "My room feels safe and my property is always safe."
- Staff had received training in safeguarding people from abuse and could describe the different types of abuse people were at risk from. They knew how to report concerns.

Staffing and recruitment

- At our inspection in June 2017 we found there were not sufficient numbers of staff to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider remained in breach of this regulation at our inspections in January 2018 and May 2018.
- At this inspection we found there were still not sufficient numbers of staff to meet people's needs.
- All the staff we spoke with on Holly unit told us there were not sufficient staff to meet people's needs.
- One member of staff identified two residents they felt did not get the support they needed and as a result, situations could sometimes escalate between residents.
- We saw one person press their call bell and call for support three times. The carer told them they were busy but would get to them as soon as they could. This person pressed the call bell again 30 minutes later but staff still had not gone to support them.
- Three people lived in Holly Cottage and were being supported by two staff. However, these staff should have been providing one to one support to two of these people. This meant that the staff supporting the people with the one to one, were also supporting the third person in the unit. This meant that they were not fulfilling the requirement of one to one support for the other two people.
- In the rest of the unit staffing had not been adjusted to take account of the fact that some people required one to one care, while others required two carers to support them. Staff told us that this meant sometimes people who required two people to support them had breakfast in their rooms because there were not two staff available to support them to get up in time for breakfast.

The failure to ensure there were sufficient numbers of staff to support people's needs was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We looked through staff files and found that there were procedures in place to ensure that staff were suitable to work in this type of service.
- While checks were completed prior to staff starting work, in some files we found records were incomplete, and it was not always recorded when issues were followed up. For example, the criminal record was missing from one file which the Registered Manager sent to us after the inspection.
- The registered manager told us they would review the files to ensure all records were complete.

Using medicines safely

- Medicines were stored securely.
- There was a system in place for ordering and giving people their medicines as prescribed.
- There were regular checks of medicine records and there was a system in place to report incidents and investigate errors relating to medicines.
- Members of staff handling and administering people's medicines had received training and had been assessed for their competency to handle and give people their medicines safely.
- There was guidance to help staff give people their medicines prescribed on a when required basis consistently. However, pain assessment tools were not in use for people prescribed pain-relief medicines in this way and who were unable to tell staff about their pain.
- Staff recorded blood glucose checks for people who were prescribed medicines for diabetes, however, some records had not been updated to accurately reflect the frequency of checks needed or the blood

glucose levels at which further action was needed.

Preventing and controlling infection

- Staff understood how to prevent and control the spread of infection. Buildings were clean and odour free.
- People told us their rooms were cleaned every day.
- We observed staff using gloves and aprons when they were supporting people.
- Housekeeping staff were employed to carry out cleaning and laundry duties. They completed schedules to ensure that all cleaning tasks were carried out.

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

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
- We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
- The service was not working within the principles of the MCA and systems did not support people to have maximum choice and control of their lives.
- We saw mental capacity assessments in people's files, but these were blanket assessments and not specific to each activity or care tasks and there were no records of best interests' decisions to provide guidance to staff on how to support people with decisions if they did not have capacity. For example, where restrictive practices were used such as alarms on people's doors there were no separate Mental Capacity Assessment or records of best interests' decisions.
- Staff did not have a full understanding of the MCA and DoLS legislation and some were confused between the Mental Capacity Act and the Mental Health Act. Staff did not demonstrate they had a clear understanding of how to apply legislation. One staff member told us DoLS would be required for person requiring bed rails even if they had capacity. DoLS is only required where people lack capacity.

Failing to ensure accurate guidance for staff to support people to have maximum choice and control over their lives, and failure to ensure that staff are familiar with the principles of the MCA is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Where the service had made applications for DoLS we saw that they followed these up with the supervisory authority if they hadn't been authorised.
- Staff attended training in mental capacity and DoLS and this was also an area that the registered manager was addressing as part of new competency assessments being introduced for staff.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's care records included holistic assessment of their needs. The assessments covered medical

diagnosis and medicines, nutrition and hydration, sleep, behaviour, mobility and falls.

- Care plans were person centred and included details about people's preferences and choices and how they preferred to be supported.

Staff support: induction, training, skills and experience

- People told us staff were competent to carry out their roles. One person said, "I think the staff are well qualified and have been trained professionally. The staff are excellent."
- Staff told us they had received the training they needed to carry out their role.
- We could see from the records that staff had completed training in areas such as basic life support, equality and diversity, moving and positioning, safeguarding and infection prevention and control.
- Staff told us they had feedback from managers about how they carried out their role. However, at the time of inspection there was no formal competency checks on carers.
- A new competency framework had been introduced for team leaders and the registered manager showed us the competency framework they planned to introduce for all care staff. This will allow the registered manager to monitor the effectiveness of training and the competency of staff to carry out their duties.

Supporting people to eat and drink enough to maintain a balanced diet

- People were supported to eat and drink enough to meet their needs.
- There was a four weekly menu that was rotated. People were asked what food they would like at resident meetings and the hospitality services lead put together the menu based on people's choices.
- The menu included a variety of dishes to provide a healthy balanced diet and included a meat and fish option each day. There was also an 'alternatives' menu that people could choose from if they did not like the options available for the day.
- There was a list of people's dietary needs in the kitchen. This included preferences as well as allergies and whether people needed food prepared in a particular way because of a choking risk.
- Staff knew people's needs well and were aware of those people that needed encouragement to eat or who were on fortified diets.
- There was a book with photographs of each of the menu choices as well as the alternatives menu. This was used to show to people when they made their choice each day for what they wanted to eat for each meal. However, the pictures were not displayed on the wall to remind people what the choices were. At lunch time several people told us that they could not remember what they had chosen.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- We saw from the records that people were supported to attend health appointments such as the GP, mental health support or speech and language therapists.
- Records of visits, the outcomes and any letters or records of assessments were included in people's care records.
- We saw records of annual reviews for people who had received mental health support in the past.

Adapting service, design, decoration to meet people's needs

- Most of the premises were adapted to meet people's needs.
- In the houses that were currently occupied people had ensuite facilities as well as their own kitchenette.
- Shower rooms were accessible and with rails for people who needed support with mobility.
- Corridors were decorated with photographs and art work and each house had a noticeboard with information about activities and events happening.
- However, there was little visual signage around the buildings and we observed one person became lost and disorientated when trying to find the toilet. More signage with pictures would help people orientate themselves around the buildings independently.

- One annexe was occupied by people who had visual impairments and the decoration was very bland with white walls.

We recommend that the provider upgrade the decoration of the premises in line with best practice guidance for people who are visually impaired.

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

People did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- The service did not have the systems in place to ensure that it was caring. For example, risks were not always assessed to keep people safe.
- People thought the staff were kind and caring. One person told us, "The staff here are very caring, nine out of ten." Another said, "The staff know me very well and listen to me." One relative told us, "They have empathy and sympathy."
- Staff used games and activities to get to know people. We saw one member of staff playing a game with a ball which had questions on it such as 'favourite film, favourite colour.' This enabled staff to find out more things about people. For example, in answer to a question about long journeys one person said they had been to Spain. The carer said they did not know they had been to Spain and that sparked a conversation with the carer to find out more.

Supporting people to express their views and be involved in making decisions about their care

- People told us they were involved in making decisions about their care. One person told us, "Staff talk to me about the care plan. I feel very involved in the care plan. I make decisions about the way my care is given and how I like things done."
- Care plans included details about how people wanted to be supported, as well as details of people's life history to help staff get to know them.
- A new keyworker system had been introduced so that key workers would sit down each month with each person to check they were happy with the care plan and to see if they wanted anything adding. One person told us, "My keyworker is [name] I see her three times a week."

Respecting and promoting people's privacy, dignity and independence

- At the last inspection we found that people's dignity was not always preserved. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- At this inspection we found that improvements had been made and the provider was no longer in breach of this regulation.
- Due to staffing levels people sometimes had to wait for care which did not always respect dignity.
- People told us that staff respected their privacy and dignity. One person told us, "I am respected because I am a human being." Another said, "I am 100 percent respected by all the staff."
- We observed care staff escorting a person to the bathroom. They checked that the person was okay and then left the room and closed the door to give them some privacy. They waited outside until the person said they had finished.
- People told us that staff supported them to be independent. Staff described how they encouraged 'small steps' in independence such as making a cup of tea or encouraging people to hold a cup themselves rather

than holding the cup for them.

Is the service responsive?

Our findings

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

People's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- At the last inspection we found care was not always person centred. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- At this inspection we found that there had been improvement in this area. The service was more personalised to meet people's needs. However, in Holly House staff did not always have capacity to respond to people's needs individually and people had to wait for care.
- Since the last inspection two activities workers had been appointed that had a regular programme of activities chosen by people using the service. The activities workers told us they needed more time to be able to focus on and engage people who stayed in their rooms.
- Care records included information about people's life history for example occupations, hobbies and interests throughout their life.
- People had a one-page profile that provided brief information on how to support people for example, 'Not a morning person,' or 'Encourage to go shopping.'
- People regularly went out if they wanted to and on both days of the inspection we saw people going out to lunch. On the second day it was a sunny day and they went to the coast as well.
- People were also taken out in the community on a one to one to go to cafes or to do shopping. One person told us on the first day of inspection that they wanted to go to the hairdresser to have their hair coloured. Carers told us that an appointment had been made and we saw on our second day of inspection that this person had been to the hairdresser.
- Activities happened in the living rooms of the houses, but there was also a dedicated activity space called 'the cabin' that was used for one to one work for people who wanted to do activities on their own.
- Staff told us that with some people it took a lot of encouragement for them to take part as they had been used to not doing activities for a long time.

Improving care quality in response to complaints or concerns

- We could see that there was a complaints procedure in place.
- There had not been any complaints since the last inspection.
- People knew how to make a complaint. One person told us, "If I were to complain the staff and management would take my concerns seriously."

End of life care and support

- People had a section in their care plan called, 'Hopes and concerns for the future.' This included details such as whether there was a Do Not Attempt Resuscitation (DNAR) in place and whether someone would want to go to hospital.
- One person had an end of life care plan which included anticipatory medicines.
- The manager told us that they will be doing more work in this area and were planning to do end of life care

training with staff.

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility;
Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider has been in breach of one or more regulations since March 2015. At our inspection in June 2017 we found that the service was not adequately monitored to manage and monitor risks and to improve the quality of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider remained in breach of the regulation at our subsequent inspections in January 2018 and May 2018.
- At this inspection we found that improvements had been made in some areas, but we continued to have concerns about the management of the service.
- There were continued breaches of regulations 12 and 18 and a new breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider has failed to provide safe care and treatment and ensure adequate staffing at the last three inspections of the service.
- There were systems in place to monitor quality, but audits were not robust in all areas. The registered manager said that they aimed to do spot checks on support plans weekly to ensure they were all up to date. They said that they had not been able to do this recently. The last audits we found were carried out three months prior to our site visit and only on three files.
- Issues within care plans such as incomplete records around mental capacity assessments had not been highlighted and oversight of the management of risks had not been identified.
- Reviews of incidents and accidents were not always carried out which meant that lessons were not always learned, and systems improved for the future.
- Audits from the fire drill did not clearly state what had been put in place to address issues arising as a result of the drill, although the registered manager told us that they planned to put more staff through fire marshal training to improve response to the alarm.
- There was no review of staffing levels to ensure that one to one care needs were met, and that people received personalised care.

Failure to ensure robust auditing processes are followed is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The service had an action plan in place that they were working through with the support of the local authority. This was bringing about positive changes within the service.

- The registered manager told us they had been focussing on staff culture and had worked hard to create a more positive and open culture. On the day of inspection, we saw signs for the behaviour of the month, 'There are not tasks to complete when we are providing support, only activities. When we are providing care, we need to think about how much we involve people in the activity.' The registered manager told us they have a different behaviour each month and encourage staff to come up with the behaviour.
- The service had also focussed on a policy of the month as a way of encouraging staff to read and understand policies. The policy in the month of inspection was Equality and Diversity.
- The provider had allocated funds to the development of person-centred activities for people. This had made a big impact on the ability of the service to respond in a person-centred way to individuals.
- People's files were more person centred, people were involved in developing their support plans. All of this contributed to a more person-centred culture within the service.
- Staff enjoyed working at the service and told us they felt supported in their teams. The registered manager told us they had recently created six team leader posts through internal promotion. They had a three-month induction and training programme assessing their competence as a team leader.
- There was a feeling amongst staff that there was a need for more staff in order to support people and meet their emotional and mental health needs rather than simply carrying out care tasks. This was the one area that staff felt management had not responded to.
- The registered manager told us they had developed links with a local higher education provider to enable staff to use the portfolio evidence to enable them to progress to further training.
- The service was continuing to improve the environment. At the time of inspection, the communal living room in one of the houses was being refurbished and there were further plans in place for improvements.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The organisation engaged people who used the service. Several people told us they had completed questionnaires and attended resident meetings. Questionnaires were in an easy format to read using pictures to make it easier for people to complete if they found it difficult to read and write.
- The new key worker system was helping to make sure people felt involved in their care plans and that care plans were regularly reviewed and kept up to date.
- We could see from the results of the questionnaires people were positive about the service.
- Staff had also completed a survey. 75% of staff said that they felt their work was valued and 62% said they got recognition when they did a good job.
- The provider had also developed an above and beyond recognition award for staff. Team Leaders nominate staff for the award which also includes a financial bonus.

Working in partnership with others

- The organisation worked in partnership with other professionals. They worked closely with mental health teams to support people with their mental health needs.
- The service worked closely with commissioners to ensure that the service was meeting people's needs.
- The service had developed links with venues in the local community that the people using the service liked to visit for lunch or outings. This helped people benefit from and become involved in the community.
- The service had links with theatre companies that came to the service and adapted shows to enable people to get involved.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Systems and processes did not support people to consent to their care. Regulation 11 (1)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Not all risks to people's safety had been assessed or practical action taken to mitigate such risks. There was not consistent monitoring of safety incidents to prevent them happening again in the future. Regulation 12 (2) (a) (b).
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	A lack of identification of risks and lack of robust auditing systems resulted in a lack of learning in order to manage risks, improve care and prevent mistakes happening in the future. Regulation 17 (1) (2) (a) (b) (f).
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	There were not sufficient numbers of staff to meet peoples needs. Regulation 18 (1)

