Ambient Support Limited

Swan Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Swan Court is an extra care housing scheme, providing personal care for up to 24 people with sensory impairment and/or physical disabilities and older people. Some people using the service were living with dementia.

At the time of our inspection five people were using the service. People using the service lived in flats, having their own private living space, kitchen facilities and bathroom. The flats were housed within one building, which was linked to a residential home on one side. People had access to a communal garden and dining area, although the use of some communal spaces had been subject to restrictions due to the COVID-19 pandemic.

People's experience of using this service and what we found
We found risks to people using the service were not clearly identified and managed. We also identified concerns in relation to the safe management of medicines. People indicated they felt safe and spoke positively about the support they received from staff. One person told us, "I am well looked after, constant attention, the helps [staff] are very positive, and try to make life comfortable." Another person described the staff, advising, "[They are] always helpful…I don't know their names."

We found the service was not effectively managed and monitored. Audits had failed to identify some of the issues we found, including concerns in relation to the safe recruitment of staff. At the time of our inspection, a manager and deputy manager provided support following the departure of the previous registered manager. The management team were motivated to make improvements and some work had commenced, such as the introduction of an electronic medicines system. There was a commitment to promoting people's independence and reducing unnecessary paperwork. However, we found not enough improvement had been made following our last inspection.

Some people using the service experienced cognitive impairments, and we found people had varying levels of awareness in relation to the management of the service. Some people were aware of the care coordinator and provided positive feedback. One person told us, "I assume she does her job well, as I'm well looked after." Another person added, "They are always asking if everything ok." We received mixed feedback from relatives regarding the effectiveness of management. One relative told us, "The ladies that work there are lovely, [care coordinator's name] is an asset…I feel they've been quite reactive rather than proactive on occasion…care is brilliant but communication isn't." A second relative added, "I get the sense it's very well organised."

Some people living at the service experienced memory loss and required significant assistance from staff. Some people did not readily accept staff support and needed encouragement with tasks such as personal care, eating and drinking. We found staff were knowledgeable about the people they support and concerns for people's welfare were shared with appropriate agencies such as the local authority.

People using the service lived in flats and feedback showed people valued having their own personal space. Staff supported people by following a care plan which outlined daily visits. Staff remained onsite which meant they could have more frequent contact with people, and staff described spending additional time engaging with people to help mitigate the isolation people experienced during the pandemic. People could use an alarm system to seek staff assistance, for example, in the event of a fall. One person described the advantages of extra care housing for them, explaining, "I have shower, [my] own bedroom, sitting room, [my] own cooker, shopping…if I press, someone will come."

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 12 December 2019). The service remains rated requires improvement. This service has been rated requires improvement for the last four consecutive inspections.

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection enough improvement had not been sustained and the provider was still in breach of regulations.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 10 October 2019. Breaches of legal requirements were found in relation to governance of the service and safe care and treatment. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Swan Court on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the safety of people's care and support, the safe recruitment of staff and the governance of the service.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Swan Court

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by one inspector.

Service and service type
This service provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is rented and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

The service did not have a manager registered with the Care Quality Commission. When a manager is registered with the Care Quality Commission, they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

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

Inspection activity started on Wednesday 16 June 2021 and ended on 25 June 2021. We visited the office location on 17 June 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We also sought feedback from the local authority safeguarding team.

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service and two relatives about their experience of the care provided. We spoke with nine members of staff including the care coordinator, four care workers, one housekeeper, one agency care worker, and a manager and deputy manager who were providing management support at the service in the absence of a registered manager.

We reviewed a range of records. This included five people's care records and medicines records. We looked at six staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to review records shared electronically and continued to seek clarification from the provider to validate evidence found. We sought feedback from professionals and received a response from six professionals during the inspection process.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant 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.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found some improvements had been made but there was still a breach of the regulation.

● Some care plans and risk assessments contained contradictory or out of date information, which could have placed people at risk. One person using the service had been reviewed in hospital due to swelling of a limb. Their care plan documented the initial medical condition suspected and stated this was ruled out. The care coordinator explained a different medical condition was later diagnosed requiring antibiotic treatment. This condition can be recurring in some individuals and if not treated is at risk of spreading to other parts of the body. The correct diagnosis had not been updated within the person's care plan. This could have placed the individual at risk if a staff member less familiar with the person's medical history identified a similar concern, as they would be at risk of relaying incomplete information to a service such as NHS 111 when seeking advice.
● One person using the service had diabetes and was at risk of hyperglycaemia and hypoglycaemia due to poor eating habits. Due to significant concerns the person would forget they had eaten and would eat excessively, the person had agreed for their food to be stored in the staff fridge and cupboards but later agreed for the food to be returned. We found risk assessments had not been updated in response to changes in the person's wishes about access to their food, and the care plan did not describe the physical symptoms of hyperglycaemia and hypoglycaemia. Whilst staff could describe actions they would take if they found the person unwell, some staff we spoke with either had not received, or could not recall, diabetes training, and some told us they used knowledge gained from family or friends. This could have placed the person at risk as some staff could not fully describe symptoms of hyperglycaemia and hypoglycaemia.
● One person had a history of epilepsy prior to moving to the service, and we viewed the risk assessment in place. The risk assessment had been set to archived status on the electronic system, meaning it was not accessible to care staff referring to electronic records. The care coordinator told us they had developed the risk assessment using information available online about epilepsy and a general diagnosis of epilepsy confirmed by the GP. The service had not asked the person for more detailed information about their seizure

history, such as how seizures presented, and had not included information from the person's family that seizures occurred most often at night. Records also showed three staff had not received training in relation to epilepsy awareness, although staff we spoke with understood the importance of keeping the person safe if a seizure occurred, monitoring the duration of the seizure and seeking medical advice as needed.

● Some people using the service were supported to apply emollient creams. Emollient creams can be easily transferred from skin on to clothing and bedding, and testing has shown increased fire risks when fabrics are contaminated. Therefore, a risk assessment should be in place. We viewed the records for an individual who smoked cigarettes and was supported to apply emollient cream to their face. We were advised information about emollient creams was included in a service risk assessment relating to the control of hazardous substances (COSHH) however for the individual we reviewed, the heightened risks associated with smoking were not clearly documented for staff within their records.

● One person using the service was prescribed an anticoagulant blood thinning medication. A risk assessment had been created outlining the common side effects of taking the medication and the importance of seeking immediate medical attention for any injuries due to increased risks of bleeding. At the time of our inspection, the risk assessment was set to archived status on the electronic care planning system, which meant it was not accessible to care staff checking the person's electronic records.

We found no evidence people had been harmed, however systems were not robust enough to demonstrate risks were effectively managed. This was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was responsive to our feedback and immediately started work to update risk assessments and care plans to ensure information relating to risks were robustly recorded and up to date. We viewed updated assessments in relation to the risk management of epilepsy, diabetes and emollient creams.

● Records showed risks in relation to fire safety were considered. Each person using the service had a personal emergency evacuation plan (PEEP) and a fire risk assessment was in place. Records showed the fire alarm was tested on a weekly basis, using a different call point to ensure over a period of time all fire alarm points would be checked. Due to fire safety concerns in relation to the construction of the building, the landlord had appointed fire watchers to conduct regular patrols. During our visit we observed the watchman respond quickly to a planned test of the alarm to check there was no emergency.

● Some people using the service were at risk of falls. We observed falls risk assessments were updated in response to incidents, and staff we spoke with understood the importance of encouraging people to use their walking aids.

● Some people using the service were at risk of dehydration. We viewed the records for one person living with dementia who didn't drink well. The service completed a risk assessment and two additional daily visits were added for staff to offer a drink and snack, and engage the person in conversation which encouraged them to drink. Staff were aware of the risks and documented when they had encouraged the person to accept a drink. A staff member told us, "[person's name] is very forgetful and doesn't remember where breakfast items are…he has two other calls [visits] to sit with him until he has drank it, it is quite a prompt to get him to drink."

● One person using the service was at risk of self neglect and did not readily accept staff support to maintain their personal hygiene. At the time of our inspection the service was seeking support from the local authority due to concerns for the person's welfare. Daily records showed the person normally declined support with personal care and would only allow staff to wash certain areas of their body. All staff we spoke with were aware of the concerns and described encouraging the person, and making return visits to their flat, to try to offer encouragement.

Using medicines safely

At our last inspection the provider had failed to accurately stock check medicines and we found topical gel and lotion which had no opening date recorded and a flammable cream was stored on a kitchenette worktop. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found some improvements had been made but there was still a breach of the regulation.

● One person using the service was prescribed a transdermal patch. Patches are thin pads with an adhesive back that are applied to the skin, and medicine from the patch is absorbed into the body over a period of time. Records showed staff had applied the patch on six occasions but only signed and dated the accompanying body chart on one occasion to show where the patch had been applied. Although the individual preferred to have the patch applied to the same arm, this was not in line with documentation best practice guidance. Staff should record the application of each patch and include the specific location, and also document when the old patch has been removed in a similar way to documenting when the patch is applied.
● One person using the service preferred to administer their own medicines when possible, but sometimes required support from staff. Records showed, and staff confirmed, there were occasions when staff either prompted or assisted the person to take the correct medicines. This included removing medicine from original packaging. At the time of our inspection staff did not record this medicines support within a medicines administration record (MAR). Some staff told us they added an update to the person's daily records, some updated the staff communications book and some staff were aware they could log a note on the electronic medicines system. Recording was not in line with best practice, which states staff should make a record each time they provide medicines support. This must be for each individual medicine on every occasion.
● We found discrepancies in recent medicines stock checks. An electronic medicines system had been recently introduced, which enabled staff to scan medicines boxes on arrival, which updated stock amounts. Staff were required to complete manual stock checks of medicines and update the electronic system. Electronic records we reviewed showed what appeared to be miscounts. For example, on one date staff had booked in 168 tablets for a medicine required at a dosage of six tablets per day. The stock take the following day counted 103 tablets. A manager stated records showed a staff member had counted a person's medicines three times on the same day and logged three differing counts. The manager had identified additional training was required for staff.

We found no evidence people had been harmed, however systems were not robust enough to ensure effective medicines management. This was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was responsive to our feedback. Immediate action was taken to introduce a medicines administration record (MAR) for one individual and the manager showed us an improved document which would be used to record the administration of transdermal patches. The manager also confirmed staff would be offered retraining in medicines stock taking following the introduction of the new electronic medicines system.

● We observed safe storage of medicines. People's medicines were stored in locked wall mounted cabinets in their own flats. Creams and topical gels had open date labelling and were stored in people's bedrooms or bathrooms. One person using the service required their medicine to be refrigerated. Records showed staff

checked the fridge temperature daily to ensure a suitable temperature was maintained.
● Staff received medicines training, and their competency was assessed. Staff described providing safe medicines support and confirmed they had been observed and supported during the recent introduction of an electronic medicines system. One staff member commented, "I got training…for the first three to four times we were always watched [whilst administrating medicines] and [care coordinator's name] was showing us what to do."
● Some people were prescribed as and when required (PRN) medicines. Instructions for the use of PRN medicines were available within people's flats for staff reference. Where a minimum time period was required between the use of PRN medicines, such as a four hour gap between use of pain relief, the electronic medicines system would alert staff to help prevent medicine errors.
● The electronic medicines system supported the safe management of medicines. The system provided an alert when medicines stock was running low and managers could see any instances where staff had used the electronic device to scan the wrong medicines box. This could help managers identify staff who may need additional training or support.

Staffing and recruitment
● Staff files did not include a recent photo. Two staff files did not contain a photo, two staff files contained expired staff identity (ID) cards and two staff files included an undated photo, so it was unclear how recently the photos had been taken. The manager explained when the current provider had issued staff ID cards, the photographs were not uploaded to staff HR records.
● We found two staff files contained no proof of identification and disclosure and barring service (DBS) checks had not been completed in line with the provider's policy, which required staff to have an enhanced DBS check. Information in staff records suggested two staff checks were made in 2003 and a third staff member's check was dated 2004. These checks were made as part of a previous system known as the criminal records bureau (CRB). Staff were asked to make a self-declaration on a three yearly basis to confirm they had not received any criminal convictions, cautions or warnings since their last declaration.
● The service had not reviewed how health issues disclosed during recruitment, when the service was under a different provider, could impact an individual's ability to work safely, meaning there was no evidence reasonable adjustments had been considered. We identified two members of staff who had declared health issues including a spinal problem, but there was no evidence this had been explored to consider risks to staff themselves or people receiving support.
● Gaps in employment had not been identified by the previous provider, and there was no evidence staff files had been reviewed by the current provider to identify and explore gaps in employment history with current staff. One person's staff file did not contain an application form, interview record or references.

Systems were not in place to review whether staff had been safely recruited, including the review of DBS checks for staff recruited under a previous provider's management. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was responsive to our feedback. The manager requested all staff submit a recent photograph and told us staff would be required to present identification documents and complete a new DBS check.

● People using the service told us they felt supported by staff and confirmed staff responded to the emergency buzzer if they needed assistance. Staff were based on-site throughout each daytime shift and this provided a level of flexibility. For example, if a person wanted to lie in, staff would offer to come back and support the person with their breakfast and morning personal care at a later time to suit their preferred routine.

● Records showed all staff had received training in subjects including health and safety, medicines administration, infection control, data protection, safeguarding adults from abuse, mental capacity act and dementia awareness. Many staff had worked at the service for several years, and staff spoke with experience and insight about the needs of people they support.
● At the time of our inspection the provider had recently reviewed the mandatory training offered to staff, updated how frequently training should be refreshed and had developed yearly competency checks in areas such as safeguarding awareness and medication. Staff had been given a deadline to complete overdue training to ensure compliance.
● Records showed, and staff told us, they received regular supervision and a yearly appraisal. A staff member told us about their experiences of supervision, commenting, "If you have any concerns, you can talk about them and sort them out. Or if they have any concerns with me, then it works both ways."
● Staff were sometimes lone working at the service. Staffing hours were determined in partnership with the local authority who assessed the needs of people using the service. Additional staff hours were also scheduled for housekeeping and administrative duties. At the time of our inspection lone working staff acted as shift leaders, and staff described contacting GPs and supporting family and professional visitors to take COVID-19 tests before entering the building. Comments from staff included, "Some days flow but another day, I could be trying to catch up", "You have to keep up a good pace of work, no margin for sitting down" and "I do feel on a morning shift working on my own is a struggle… at the moment I feel with [COVID-19] testing with one person in the morning is a lot of pressure." The manager confirmed feedback would be sought from staff to review the concerns staff had raised with us.

Systems and processes to safeguard people from the risk of abuse
● During our inspection we identified one incident where a person using the service had fallen and sustained an injury. The current manager agreed this incident should have been reported to the local authority and submitted a retrospective safeguarding referral. We found other potential safeguarding concerns had been reported to the local authority as required.
● Paper records relating to safeguarding concerns were found to be disorganised and did not always provide supporting evidence of follow up actions taken. The manager had recently created a log to record concerns raised and note any follow up action required. No actions were logged for the three safeguarding referrals recorded. We raised concerns and the manager agreed to also document the outcome of referrals if further follow up actions were not required. We sought additional information regarding safeguarding concerns and were satisfied appropriate actions had been taken to safeguard individuals at risk.

We recommend the service improve recording in relation to the management of safeguarding concerns, to ensure the service can demonstrate effective systems are in place to safeguard people using the service from abuse.

The service was responsive to our feedback and agreed to improve the documentation in relation to safeguarding. The service also provided detailed feedback in relation to the safeguarding concerns we reviewed.

● People and their relatives told us they felt safe. A person using the service commented, "All staff [are] very helpful, [I] feel quite safe."
● The service had a safeguarding and whistle-blowing policy in place. Records showed, and staff told us, they had received safeguarding training. One staff member's refresher training was overdue at the time of our visit and we were advised all outstanding training would be booked.
● Staff understood signs of abuse and generally understood their responsibility to raise safeguarding concerns internally and externally with the appropriate agencies. A staff member described potential

indicators of abuse, and advised, "[I would] seek help from management and tell a senior member of staff."

Preventing and controlling infection

● We were not fully assured the service had robustly monitored staff testing to ensure staff adhered to the service's testing schedule. Records relating to staff testing for COVID-19 infection were poorly maintained. We viewed testing records for a period of nine weeks and found several gaps in records. The service liaised with staff to confirm whether testing had taken place and provided an update which indicated some gaps had been administrative errors. The service confirmed this would now be monitored on a weekly basis by the care coordinator and a new template to record test results was put in place.

● People were protected from the risk of infection. We observed, and people using the service told us, staff wore appropriate personal protective equipment (PPE). Staff had received training in relation to infection control and had access to sufficient supplies of PPE. The service had assessed the competency of staff in relation to infection control, including the use of PPE and hand hygiene. A staff member commented, "I had Zoom training and had to demonstrate how to don and doff PPE and wash my hands, [training] has been very good."

● We observed the service to be clean and well ventilated throughout. Records showed staff frequently sanitised high touch points and cleaning took place within communal areas and people's flats. This enabled staff to support people to maintain their homes in a hygienic condition.

● The service's infection control policy had been updated in response to COVID-19 and we observed appropriate risk assessments in place. Risk assessments considered the risks to people using the service, visitors and staff.

● People had been supported to minimise the risk of catching and spreading infection. People using the service had access to regular testing, and people moving into the service were supported to self-isolate for fourteen days to minimise the risk to others. People had access to a communal garden but some communal spaces were not in use. We were advised the fabric chairs in the communal lounge could not be sanitised and therefore the chairs had been removed from use to avoid the transmission of infection.

● Visitors had their temperature taken and were asked about their health, recent travel, and contact with others, to identify signs of infection. On arrival, there was clear signage and visitors were encouraged to sanitise their hands and wear appropriate personal protective equipment (PPE). Visitors were also encouraged to take a rapid lateral flow COVID-19 test before entering the building. Test kits were readily accessible on a well-stocked trolley near to the building entrance and staff supported visitors such as family members with testing.

Learning lessons when things go wrong

● Staff understood their responsibility to report incidents of concern and systems were in place to share key information and learning following incidents. Staff lone working at the service used handover discussions and a communication book to share updates. We observed accident forms describing events such as falls were printed and attached to the communication book for staff to review. This allowed staff working infrequently at the service to remain up to date. A staff member commented, "When I've been off [work], it's quite a lot of reading, it has to be done."

● Staff were also updated through team meetings, supervision sessions or ad-hoc discussions. A staff member advised, "Yesterday we had a little staff meeting. We're able to discuss issues at a meeting, individually or sometimes things are communicated via communications book depending on how sensitive it is…I feel pretty informed with everything, I don't have any concerns."

● Accidents and incidents were logged electronically, and we observed information relating to safeguarding, compliments and complaints stored in paper files. Whilst learning from individual concerns was shared, no formal systems were in place to regularly review information to monitor for themes or trends. The manager demonstrated an electronic system which could be used to see an overview of accidents and incidents

across the service. There was no evidence this had been used by the previous registered manager. The manager planned to commence monthly and quarterly reviews to enable themes and any wider learning for the service to be identified.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

During our three previous inspections in February 2017, August 2018 and October 2019 we found a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have a robust quality assurance system in place to effectively monitor the safety and quality of people's care.

During this inspection we found some improvements had been made but there was still a breach of the regulation.

● Since our last inspection care plans and risk assessments had been created using an electronic system. Staff also had access to a shorter, quick reference care plan, which was stored as a paper copy in the staff office. We found electronic care plans often contained out of date or contradictory information. This meant records did not present an accurate and contemporaneous record in respect of each person using the service. We found one person's care plan referred to a catheter which had been removed more than four months prior to our inspection visit. Another person's record referred to them receiving a daily cooked breakfast from the care home next door and advised the person's other food was kept in the staff fridge. The care plan had been poorly maintained and this information was no longer up to date.
● We found audits of care plans had not taken place in line with the provider's policy which stated monthly audits should be conducted within the service. Between January 2020 and June 2021 we found only six audits had taken place.
● Audit systems were not fully effective, because they had not identified some of the concerns we found. An annual audit had been conducted by the provider in April 2021 and this reviewed recruitment and training of staff. In relation to the statement 'Staff are up to date with their mandatory training' an answer was recorded of 'This standard is met'. We found the manual handling training for two members of staff was overdue, the food hygiene training for one staff member was overdue and one staff member had not received either basic life support or emergency first aid at work training, and lone worked at the service. The manager established there was an unwritten verbal agreement that staff who were not first aid trained could access help from the adjoining care home. Audits also failed to identify concerns we found in relation to staff disclosure and barring service (DBS) checks.

● Efforts had been made to reduce unnecessary paperwork, however following the departure of the previous registered manager, the service was unclear as to whether certain documents had been in place. For example, a survey of people and relatives had been undertaken during 2020. We found no evidence there had been analysis of the findings, or evidence an action plan had been created, because the service was unsure as to whether this had been completed by the registered manager and this information had not been handed over during their departure.
● Records logged accidents and incidents, compliments and complaints, and safeguarding concerns. Whilst individual incidents were explored and learning shared, effective systems were not embedded to monitor for themes or trends within the service. There was no evidence the previous registered manager had used an electronic system which could track accidents and incidents.
● We reviewed a falls tracker used by the previous registered manager, which was last completed in September 2020. This showed two unwitnessed falls for the same individual. The document described each fall but contained no analysis or outcomes, so it was unclear whether any learning had been identified and how the information had been used. This meant the audit tool was not effective.

Management systems were not effective to promote high quality, person centred care. This was a repeat breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was responsive to our feedback. The service confirmed staff would receive outstanding mandatory training. A risk assessment was recorded in relation to first aid cover at the service until all staff could receive first aid training. The current manager planned to introduce monthly and quarterly audits to enable a wider analysis of incidents to identify potential learning within the service. The service also planned to further audit and update electronic care plans and risk assessments.

● At the time of our inspection a registered manager was not in place, however the service was supported by a manager and deputy manager from another service managed by the same provider. This provided support for the care coordinator who was involved in the day to day running of the service. The care coordinator had found this input supportive, they advised, "They said things we didn't need to do, or things we should be doing… [it's] been a good support, I would have been left stranded."
● Audits had identified concerns in relation to care plans and risk assessments. The annual provider audit identified a need for further audits of care plans and risk assessments to ensure information was consistent between documents. A care plan audit completed May 2021 had provided detailed feedback to enable the care coordinator to make necessary changes and a deadline had been set for completion.
● Staff were clear about their roles, responsibilities and lines of accountability. Staff we spoke with understood the importance of reporting incidents and providing a clear handover of information between shifts.
● Confidential information was held securely. We observed paper records held securely within an office which was kept locked when not in use. Staff had access to electronic recording systems for daily notes, care plans and medicines recording. Systems required a staff login and we observed staff did not leave computers unattended. One staff member summarised, advising, "[There is] less paperwork printed out… office door is locked… staff handover is shared within members of staff, not anyone else."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People and families generally provided positive feedback about their care and support. We also heard examples where the service had helped people achieve good outcomes. A relative described positive changes following an older person's move to the service. They advised, "[Person's name] has been a recluse

for years… to see him clean shaven and without very long hair and showering, I don't think [the] bathroom was used previously…is a fundamental change."

● People spoke positively about their flats and the support they received from staff. Care plans contained people's likes, dislikes and care preferences, including information in relation to their protected characteristics. We observed flats were personalised with people's belongings and one person had been given permission by the landlord to bring their pet when they moved into the service. One person advised, "I have a bed and roof over my head, staff treat me great, [it's] nice they come and check on me."

● Following the departure of the previous registered manager, the service was overseen by a manager and deputy manager who were supporting the care coordinator to make changes. There was a clear vision to enhance person-centred care, by reducing unnecessary paperwork and ending processes more suited to care home environments, such as routine weight checks. The aim was to ensure staff had more time to engage with people using the service, and to promote independent living. Not all staff we spoke with felt they had seen significant changes, but staff generally appeared positive about the new management's input. Staff comments included, "I haven't seen anything in my role as yet, apart from care plans being a bit more up to date", "Sometimes before we just seemed to be going round in circles, now things seem to be progressing" and "I feel much safer now…[there's] not an institutional group you don't touch…a lot of people hid behind [previous registered manager's name], thought they could do what they like, I feel it's gone."

● Staff showed commitment to providing person-centred care and were knowledgeable about the people they support. We found staff upheld the principles of equality and diversity as part of their day to day work, particularly with regards to meeting people's diverse communication needs as a result of sensory or cognitive impairments. Staff also understood the dietary preferences relating to people's cultural backgrounds. One staff member told us, "We are here to give 100% to tenants [people]." A second staff member added, "When people say why are you working, I say I love the tenants, I love listening to their stories."

● Staff reported there was effective team working. The care team had worked at the service for several years and although some staff were lone working, there remained a sense of team work. Staff comments included, "[There is] good team work spirit", "I love working with different people from the team, sharing what they've got to say and listening to what I've got to say" and "We have a good team, can be quite open with each other."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● CQC sets out specific requirements that providers must follow when things go wrong with care and treatment. This includes informing people and their relatives about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The provider understood their responsibilities.

● A duty of candour policy was in place. We spoke with the manager of the service who had a good working knowledge of the duty of candour principles and the manager understood the nature of incidents which may require a formal duty of candour process.

● Staff knowledge in relation to the duty of candour had been refreshed at a recent team meeting. Minutes showed staff discussed the background to the duty of candour regulation, key principles including openness and transparency, and the process that would be followed when incidents occurred requiring a duty of candour response.

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

● At the time of our inspection a recent annual survey had been distributed to people and families. The

service explained people had been offered support to complete the survey and the results would be analysed by the provider. We viewed the results of the 2020 people and family survey. We found no evidence the results had been analysed by the service or an action plan created. The service and provider were not aware if this work had been carried out by the previous registered manager and therefore could not advise how the survey results had been used.

● Staff including the care coordinator encouraged open communication with people using the service. The care coordinator supported with people's care which meant they regularly visited people using the service and told us they sought people's feedback. People were also able to attend tenants meetings. These had been placed on hold during lockdown restrictions but a meeting was booked for shortly after our inspection. We viewed the minutes for previous meetings where people had given their views about topics such as activities and COVID-19.

● Some people using the service were able to confirm they had been asked for feedback. One person told us, "If I don't like [something] will tell them…always asking if everything ok." Another person commented, "All staff [are] very helpful, very positive thinking… I'm asked if [I'm] happy." Another person using the service, who experienced memory loss, was unclear how to give feedback, advising, "I haven't been told, if I don't like something happening, don't what [I] can do." This person confirmed they had no concerns about their support, but was not aware of how they could give feedback.

● Staff were able to provide feedback through supervisions, team meetings and an annual survey conducted by the provider. We reviewed the results of the 2020 staff survey. This showed analysis had been undertaken and an action plan was in place, which had been reviewed in February 2021. Most staff we spoke with felt able to give feedback. A staff member told us, "If I have concerns about anything I will tell…we are all quite open…it's the tenants [people] that matter and if it's about a tenant we do talk about it and sort things out."

● The manager of the service understood their duty to protect staff who raised concerns, including whistle-blowers. The manager told us about their experiences supporting staff in other locations, advising, "For some issues I met with staff off-site…protecting their anonymity. Other times for general concerns, even though there might be individuals to meet, I meet with everyone." This meant the manager could protect the identity of a whistle-blower whilst investigating concerns.

● The service had worked to maintain links with the local community. Prior to the COVID-19 pandemic, a local charitable organisation had supported the service with activities including coffee mornings. The care coordinator had maintained contact with the organisation and was aware of services they could now offer for people, such as support with transport.

Working in partnership with others

● Health and social care professionals involved in people's care indicated the service worked effectively in partnership with other organisations. The service worked closely with the local authority in relation to quality monitoring and to support reviews when people's needs changed. A professional commented, "The home have worked with us to look at improvements required and have evidenced where and when they have completed actions." Another professional added, "The review process was carried out in my client's flat, a staff member accompanied me… the worker displayed compassion and concern for my client's well-being and it was clear that she cared about his welfare."

● The service worked cooperatively with health services and we saw evidence people had been referred for healthcare support. The comments we received from healthcare professionals included, "I have found them to be responsive and proactive when dealing with people's care", "[They are] very good, if there's problem they take note, if someone new they contact me" and "I always find them to be very helpful and friendly."

● Effective systems were in place for appropriate information sharing. A daily shift leader was a point of contact for professionals visiting or telephoning the service. The service was also able to give remote electronic access to professionals such as local authority staff as part of quality monitoring arrangements. This allowed secure and effective information sharing.

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
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Systems were not in place to review whether staff had been safely recruited.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not clearly identified and managed. Systems were not robust enough to ensure effective medicines management.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service was not effectively managed and good governance was not established.

The enforcement action we took:

We served a warning notice.