Swanton Care & Community Limited

# Swanton Community Support

## Inspection report

Treeview Court
Crome Road
Norwich
Norfolk
NR3 4SL

Tel: 01603285205
Website: www.barchester.com

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| Is the service safe? | Good |
| Is the service effective? | Requires Improvement |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Requires Improvement |

# Summary of findings

## Overall summary

The inspection took place on 23 March 2016 and was announced.

The service provides support people in their own homes. At the time of this inspection, twenty four people were supported in flats on the same site as the agency office. A further 15 were supported in their own homes in the community. Most of the people using the service need support with their mental health needs.

There was no registered manager in day to day charge of the service. The registered manager had been transferred elsewhere and this had become a permanent arrangement just before the inspection. A registered manager is a person who has registered with the Care Quality Commission 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. In the absence of the registered manager, the deputy manager was fulfilling the role of acting manager. It was the provider's intention that the acting manager would register in respect of the service.

People experienced a service that promoted their safety. They received assistance from sufficient numbers of staff to meet their needs safely. There were robust recruitment processes in operation, which contributed to protecting people from the employment of staff who were unsuitable to work in care. Staff were aware of their obligations to report any concerns that people may be being abused and people were supported with advice about risks to their personal safety.

Where people needed support to manage their medicines, staff did this in a safe way and people received their medicines as the prescriber intended.

The service was not wholly effective. Staff had not been properly trained and prepared to understand their obligations under the Mental Capacity Act 2005, about how to support people to make informed decisions where their capacity to do so may be in doubt. However, improvements in this area were in the process of being made to ensure staff were more aware of their responsibilities. Not all staff had received the provider's core training so that they all had the skills and knowledge to meet people's needs effectively. However, there were plans in place to improve this.

People were supported to eat and drink enough if this was a part of their care package. People were also supported to access health professionals if they could not do this independently or their health deteriorated.

People were supported by a staff team that was kind, compassionate and who treated people with dignity and respect. People were involved in making decisions about the care they wanted to receive.

Staff understood people's individual preferences for the way they wished their care to be delivered and respected these. They communicated well with one another about people's support and any changes that

needed to be followed up. This helped to ensure people were supported in a way that focused on each person's needs.

People were confident that, if they needed to raise a complaint or concern, this would be dealt with properly and action taken to resolve issues as far as possible.

Changes in management arrangements, both within the provider's management team and within the service, compromised the ability of the service to demonstrate consistent, stable and appropriate leadership. The morale of the staff team was also affected. The new arrangements needed time to consolidate to ensure they were working appropriately, taking into account the views of people using and working in the service.

## 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.

Medicines were managed safely and people received these in a timely way if they needed support in this area.

People received support from enough staff who were robustly recruited so contributing to people's safety.

Staff were aware of their obligations to help protect people from abuse and to report concerns promptly to promote people's welfare.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

Staff were not all well prepared and trained to understand their obligations where people's capacity to make specific and individual decisions about their care was in doubt.

Although improvements were planned and underway, staff were not always appropriately trained and supported to meet people's complex needs.

People had enough to eat and drink where this was part of the care package staff were expected to deliver.

Staff were alert to changes in people's physical and mental well-being and supported people to access health professionals if this was needed.

### Is the service caring?

**Good**

The service was caring.

People received support from kind and caring staff.

People were treated with respect and their dignity, independence and preferences were promoted.

## Is the service responsive?

Good

The service was responsive.

People received support in response to their changing needs. Staff had a good understanding of people's needs and preferences.

People could be confident that any concerns or complaints they raised would be properly addressed.

## Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Changes in the staffing structure and management arrangements had not had time to embed to demonstrate consistent leadership.

There was no registered manager in day to day charge of the service but this was being addressed.

There were systems in place for assessing the quality and safety of the service.

There were systems in place for assessing quality and safety of the service but with some slippage in the way people and staff were empowered to express their views.

# Swanton Community Support

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 23 March 2016 and was announced. The manager was given 24 hours' notice because the location was a domiciliary care service. It was completed by one inspector.

Before we visited the service we reviewed all the information we held about it. The information reviewed included notifications about events taking place in the service and which the provider is required to tell us about by law. We also reviewed responses in questionnaires from ten people who used the service and five community professionals providing support and advice about people's care. These had been sent to people for completion before our inspection.

We spoke with three people who used the service. We also spoke with four staff members and the acting manager. We reviewed medication administration records for three people for whom staff had responsibility for managing their medicines. We looked at care plans and records of support provided for four people. We reviewed the recruitment records for one newly appointed member of staff, training records for the staff team, and a sample of other records associated with the quality, management and safety of the service.

Good

# Is the service safe?

## Our findings

People spoken with told us that they felt safe with the staff. For example, one person told us how they felt they were "…very safe here." Another person said, "I am happy that staff care."

In addition to people we spoke with, ten people completed questionnaires for us. These people said that they felt safe from abuse and harm from the staff who worked with them. All of the community professionals who responded to our questionnaires also told us that they felt people were protected from abuse. One mental health professional said that they had no concerns about the service. They went on to say that they felt staff provided a good and safe level of care and did their best to manage the risks associated with people's difficult and complex needs.

Staff spoken with confirmed that they had training to recognise and respond to suspicions of abuse. One staff member confirmed that if they had any concerns about someone's safety, they could raise these with the acting manager. They went on to tell us they could also contact the safeguarding team directly themselves if they needed to. They told us that contact details for the relevant authorities were displayed in the office and we saw that this was the case. We noted that most staff employed had completed relevant training in this area but that there were some omissions. Additional safeguarding training had been arranged and we saw that three training dates were displayed in the staff office so that gaps could be addressed.

We found from information sent to us that action was taken to refer concerns to the local safeguarding team when this was appropriate. We concluded that there were arrangements in place to help protect people from the risk of abuse.

We noted that people's care records contained assessments of risk to which they may be exposed and how these were to be managed and minimised as far as practicable. This included risks associated with their mental health and wellbeing and from self-neglect or self-harm. Information also showed how people may indicate that they were under stress and what support staff needed to offer to aid them to calm. Staff spoken with were clear that no restraint was used if people became distressed.

Our discussions with the manager showed that they were aware of people who may be at risk of harm or exploitation. They had supported people with advice about personal safety, how people could help keep themselves safe and be more aware of risks.

People told us that there were enough staff to support them at the times agreed in their care package. One person showed us how they had a staff duty roster so that they knew who was coming to support them and when. People's responses in questionnaires showed that they felt they received support from consistent staff and that staff stayed for the agreed amount of time. They also felt that staff did what was expected of them when they visited. We concluded that there were enough staff employed to help support people safely.

A new staff member told us what checks had been made to ensure their suitability for working in the service.

When we reviewed records we saw that these were in place. Recruitment records showed that applicants were asked for a full employment history with an explanation of gaps. We noted that references were taken up and appropriate checks made to ensure that staff appointed were not barred from working in care. We concluded that recruitment practices were robust and contributed to protecting people from the risk of abuse.

Arrangements for managing medicines were flexible and dependent upon people's needs. Subject to an assessment of risk, some people's medicines were managed by staff and others managed their own.

We noted that one person spoken with was drowsy and their speech slurred. They told us that this was because of their medicines but they needed them. The manager was aware of the concerns and working with relevant health professionals towards a solution that was acceptable to the person.

We reviewed the arrangements for storing and administering medicines. We noted that there was a book in the staff office for signing medicine keys over when authorised staff took possession of them. However, the keys had been left attached to this book. This meant that the arrangement was not working as intended to ensure an audit trail and that only staff trained in medicines management could access the keys. This was rectified during our visit and we discussed the arrangements with the acting manager.

We found that medicines administered by staff were signed and accounted for appropriately. We noted that there was one anomaly between the amounts of a medicine carried forward and the number of doses administered. There was an omission from their records when an additional supply had been obtained on the person's behalf. We discussed this with a senior support worker. We were subsequently able to account for the tablets from the amounts given and the amount remaining in the person's flat, which they gave us permission to check.

Staff responsible for giving medicines confirmed that they had relevant training and were able to give us a consistent account of the process and the checks that they made. They also told us how staff new to administering medicines were supported by more experienced, trained staff to ensure they were confident and competent to administer medicines. We concluded that, where staff were involved in supporting people with their medicines, people received these safely, in a timely way and as the prescriber intended.

Requires Improvement

# Is the service effective?

## Our findings

People told us that they felt staff knew what they were doing and were able to support them appropriately. All ten people who completed questionnaires for us said they felt that staff had the skills and knowledge to give them the support they needed.

Four out of five health professionals completing surveys for us said they felt staff were competent to provide care and support to people. One disagreed that this was the case and felt that staff were not always sufficiently skilled to meet people's needs.

We spoke with staff about their training. We noted that staff had access to qualifications in care if they wished to pursue these. However, concerns were expressed to us about some other aspects of training including the induction process. A staff member told us that it was difficult to apply the workbook they were given to complete in the first two weeks of employment. They said that this was because they had no practical experience of situations to which they could relate the theoretical learning. The process of shadowing more experienced colleagues had not worked as well as they had hoped. The acting manager was aware of the difficulties and reviewing how they might be addressed to improve the way new staff were supported and inducted into the service.

Experienced staff told us that basic training was good. However, most staff spoken with felt that the needs of people who were accepted into the service were increasingly complex. They said this could mean that meeting people's needs was difficult given the skills mix and experience of staff. For example, one said, "I don't think some staff are that skilled up and trained to deal with crisis and talking someone down can be difficult." Another staff member told us they felt, "The client group has changed…. things can blow up so staff get worried and anxious."

We found from the training records we viewed that there was a range of training considered as 'core' skills for staff to complete. We noted that approximately two thirds of the staff team were shown as having completed core training in 'positive behaviour support and working with behaviour that challenges.' Others had not. This included seven staff listed who had been in post for longer than five years. The training programme provided to us by the manager showed that training in effective communication was also considered part of core skills training that staff were expected to complete. The records showed that none of the staff had completed it.

Staff and the acting manager acknowledged that the need for more specific training had been recognised and was under review so that it could be scheduled. For example, training had been arranged to enable staff to more effectively respond to the needs of people with Asperger's syndrome. We concluded that staff were not always properly trained to meet the specific needs of those they were supporting but that this was being addressed to ensure improvements were made.

We noted that supervision was variable with some staff saying that this did not happen very often. This included a lack of regular supervision during probation periods for staff who were new to their roles.

Supervision is needed so that staff have the opportunity to discuss their role, performance and development needs. We noted that the structure and management of the staff team had changed and further changes were due. Arrangements had not yet consolidated so that supervision and support could stabilise and improve. However, staff members told us that the acting manager was someone they could go to if they needed advice or to discuss any issues. They said that they felt well supported by the acting manager.

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.

We noted that the acting manager had taken action to ensure that relevant professionals and an advocate were involved where it was felt one person may not understand the health implications of the diet they had chosen to eat. This had placed the person's health at significant risk. The manager was seeking advice about this and was aware of the importance of reflecting the person's best interests if it was agreed that they did not understand the risks to which they were exposed.

However, practice in supporting people with decision making and seeking consent was variable and not always addressed robustly within care plans. For example, we found that parts of one person's records commented that they were able to communicate verbally and understand what was said. Elsewhere the care records indicated the person had no capacity to make informed decisions. They did not refer to the specific and individual decisions that were needed. They did not show how explanations had been offered and how the decision had been arrived at that they were not able to give any informed consent about their care.

Not all staff spoken with were able to explain how they would support people to make individual and specific decisions about care if their capacity to do so might be in doubt. One staff member told us that it was left to professionals to assess people's capacity. They did not recognise the role of the staff team in supporting people whose capacity may be in doubt, with day-to-day decisions about their care, for example in relation to personal care and medicines. Other staff were clearer about how they would seek consent and recognised the fluctuations in people's mental health could impact on their decision making.

The provider's policy guidance for the MCA stated that all staff would receive training in the principles of consent, informed consent and mental capacity during induction. However, a staff member who had completed their three month probation period said they had not yet had training in this area. The training record for the staff team as a whole showed that core skills for staff included the MCA. Only three staff had dates for completion entered against their names. However, we noted that four full day training sessions in the MCA had been arranged for the staff team. We concluded that staff had not been properly trained and prepared to understand their responsibilities in relation to consent but improvements were being made as required.

Where people needed support with preparing meals as part of their care package, we could see that this was offered. One person told us that staff assisted them to do this. Another person described how others using the service had needed more assistance than them with meal preparation and that this had always been given. The need for advice in relation to shopping and planning healthy meals was incorporated into people's plans of care and recorded in the notes of the care that staff had offered to people. We concluded that, where it was necessary, staff supported people to prepare their meals and to eat and drink enough.

People told us that they saw health professionals who could help keep them well. One person told us how they had just been to the doctors and they discussed with staff the treatment that had been prescribed to them. Another person told us they felt staff understood when they were unwell. They said, "Staff weren't clinical but they reminded me about my tablets and cared about how I dressed. I had a wobbly but they helped me out."

We could see from records that people accessed their GP, mental health professionals and others who could assist to keep them well. Some did not require staff support to do this but support was available from members of the staff team if it was needed.

A visiting health professional commented in their survey that the service communicated well with their team. They felt that staff raised concerns about people's progress and welfare appropriately, when it was needed.

Good

# Is the service caring?

## Our findings

One person told us how they been able to exercise some choice about the staff who were supporting them. They said that they were involved in recruiting staff. They also told us how they had not related well to a staff member but, "… that got changed and it's OK now." They told us that they could talk to staff. Another person said they liked the staff and told us how they enjoyed spending time with staff chatting to them over a cup of tea in their flat or playing a board game.

One person spoke very positively about the relationships they had developed with staff. They said, "Staff are very kind and respectful with a good sense of humour. They talk to you about "normal" things. That really helped me." They felt that staff listened to them and supported them and went on to describe the staff as, "…very patient with everyone."

The responses we received from our questionnaires showed that people felt they had good relationships with the staff. One person made an additional comment that, "At Swanton, all the staff are good and caring." All ten people who responded felt that staff were kind to them. We concluded that people were supported by staff who had developed good, caring relationships with them.

All five visiting health professionals also responded in surveys that people were always treated with respect for their privacy and dignity. They felt that staff were kind and caring in their approach and promoted people's independence.

People's records and updates to their plans of care were held on computer. As such, they could not be signed by people to show how they had been involved in developing their plans of care and how their views were taken into account. However, people told us that they were involved in decisions about how they wanted their care to be delivered. For example, one person said, "I was involved in discussions and plans for the next step and how things could move on." Another person said they had been involved in selecting their keyworker so they could be sure it was someone they would get on well with.

All ten people who completed surveys for us agreed that they were involved in decision making about their support needs. We concluded that people were supported to be involved in making decisions about how they wanted their care to be delivered.

We observed that staff spoke with people in a respectful manner and asked for permission before entering people's homes. We also noted people being encouraged to express their concerns and anxieties moving to private areas if appropriate. They showed an insight into how people expressed themselves. This included the acting manager who recognised the way that one person signalled how they would like to talk but would not directly ask. We saw that this was responded to. We concluded that staff responded to people's needs promptly and with respect for people's privacy and dignity.

Good

# Is the service responsive?

## Our findings

One person told us how the service had responded to their changing needs and supported them. They described the agency as, "…a major part of the road to recovery." They said that, when they had experienced difficulties, the service responded promptly and helped them to improve again.

A visiting professional added an additional comment to their questionnaire for us. They felt that the management team provided as much flexibility for people as possible, taking into account their individual needs and preferences.

Staff told us how time was given to ensure that people could be matched with 'key workers' to whom they related well. One person told us how they were involved in interviews recently and thought the staff selected, "…will be good. They were very chatty." We concluded that the service took action to respond to people's preferences.

Staff were able to tell us about people's health and welfare as well as their individual needs and preferences. They gave us clear accounts about how concerns for people's well-being had been followed up. The information they gave us was consistent with what we saw in people's care records. Staff were able to describe the support they were expected to offer for people to whom they had been allocated to deliver care. We noted from discussion between staff members that they were aware of one person's complex needs, including in relation to their health, and how this was being followed up.

People's plans of care and risk assessments were compiled using a dedicated software package on the computer. This contained a 'traffic light' system showing when elements of the plans were due for review or update. We could see that they were reviewed regularly to ensure they reflected people's current needs and how staff should support people with these. Daily records showed that staff supported people in a manner that was consistent with their plans of care and assessed needs.

A staff member was able to describe how they supported a person flexibly, subject to their health. They gave us an example of a "good day" for the person and the increased opportunities they would be able to support the person with as a result. We concluded that people received personalised care that was responsive to their needs.

Support with hobbies, interests and community presence was included as part of care packages and rehabilitation for some people. Staff were able to tell us about this. One person told us about their particular interests, hobbies and the things they enjoyed doing. Again this was consistent with what we had seen in the person's care records and what staff had told us about them.

Eight people responded in our questionnaires with their views about whether the agency staff responded well to any complaints or concerns they raised. Seven were happy that this was the case and only one person was unsure. People we spoke with told us that they knew how to complain or to raise any concerns and were happy to do so. For example, one person contrasted this service with a previous service they had

used. They said, "I would look to see who was in the office before asking for help as with some staff you knew nothing would happen. Here, it doesn't matter who it is, they'll always help." They were confident that if they needed to complain about something, it would be dealt with.

We reviewed the record of complaints, which contained a complaint with a number of elements. We could see from the investigation records that each of these elements had been reviewed and discussed with one of the provider's representatives. The acting manager was able to clearly explain what action was taken to minimise the risk that the concerns would arise again. Where appropriate, action had been taken with staff to ensure that improvements were made and additional training had been arranged. We concluded that there was a proper system for investigating and responding to complaints.

Requires Improvement

# Is the service well-led?

## Our findings

The registered manager for Swanton Community Support had been transferred to another of the provider's locations on 16 November 2015. Since that time the deputy manager had been acting as manager for the service. The arrangements were initially intended to be temporary for three months but had been made permanent just before our inspection. There had also been changes in the provider's oversight of the service with a new regional manager in post.

The staffing structure within the service had also been revised. As a result of this some staff had been made redundant and others had to reapply for slightly different job roles. Some staff felt that the way this had been handled was difficult and that there had been little consultation about the changes. Staff spoken with and the acting manager acknowledged that staff morale had declined as a result. We noted that some further changes were being implemented on 1 April 2016 and so there remained an element of uncertainty about how well these would work.

Staff said that they had tried hard to ensure the care and support they offered to people was not adversely affected by the changes. They told us that some people might have been sensitive to the atmosphere but it was beginning to settle down. They said that they valued the approach of the previous manager and of the acting manager. They said they could seek support or guidance and one staff member described the acting manager as having "…an open door policy." We concluded that the acting manager was trying to continue an open and transparent approach, where people and staff could express their views.

We noted at this inspection, training was an area which needed to improve, as the provider's core training was not being well completed by the staff team. We discussed with the acting manager our concerns that the process of driving improvement, taking into account the views of people using and working in the service, had declined. Recent changes, adverse effects on morale and further changes underway meant that the provider could not demonstrate stability and consistency of leadership at this time.

We noted that the provider had systems for analysing the performance of their services. These included reviewing the numbers of adverse incidents taking place across their services and compliance with the provider's expected training. They compared the results across their services so that managers could see how they were measured against the expected and prevailing levels.

A staff member explained to us how some of the routine monitoring checks required in the service were being delegated. These had been allocated to team leaders, due to take up their appointments on 1 April 2016. They told us that this would include an audit of care records, medication audit and checks on the safety of the building from which the agency operated.

The acting manager was intending to register as a manager with CQC and was aware of the importance of completing additional training relevant to their new management role. Our discussions with the acting manager showed that they had considerable experience within the service, having originally started as a support worker. They demonstrated a good understanding of their current role and of relevant regulations.

They were aware of the events that they needed to tell the Care Quality Commission (CQC) about. We concluded that the staffing and management team structure needed time to consolidate to ensure that standards within the service were developed and improved.