Swanton Care & Community (Autism North) Limited

Swanton Community Care

Inspection report

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Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

This inspection took place on 4 and 8 January 2016 and was announced. This was the first inspection for this service since it registered in January 2015.

Swanton Community Care provides domiciliary care in the form of supported living services for young adults living with autism or a learning disability. At the time of the inspection they were supporting two young people who shared a bungalow.

The service had been without a registered manager since September 2015, however there was a manager in post who was currently completing their registration with the Care Quality Commission, they had been in post since August 2015.

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.

Supervisions were being held although they did not meet the providers own requirement to be held at least six times a year. The manager had been in post for five months at the time of the inspection and had ensured staff had attended one supervision during this time. Staff told us they did not feel well supported and had not had regular supervision or team meetings.

Safeguarding concerns and accidents and incidents were well recorded and the information was analysed for lessons learnt which included looking for triggers to behaviours and reviewing support strategies to ensure people were being cared for in the right way.

Risk assessments identified preventative measures and gave staff clear guidance on how to manage risks.

Staffing levels were set by commissioners of the service. Personalised rotas identified the correct level of support was being provided and ensured staff knew who they were supporting before they were on shift. The manager was actively reviewing the support provided to people to ensure they were neither over nor under supported. There were mixed views from staff as some did not think there were enough staff to meet people's needs at the present time.

Medicines were managed and administered in a safe way, by staff who were trained and had had their competency assessed.

Staff attended appropriate training, including service specific training such as autism and non-abusive physical and psychological interventions which ensured they had the necessary knowledge and understanding to meet people's needs.

People were actively supported and encouraged to be involved in decision making, and plans were in place which identified how staff should manage this. For example, by staff offering people two options at a time. People made their own decisions about mealtimes and were supported to have a healthy and well balanced diet.

The manager was knowledgeable about best interest decisions and people had authorisations in place which had been approved by the Court of Protection for areas of their lives which were being restricted in their best interests.

Staff approach was caring and compassionate. People were treated as adults and were supported and encouraged to be independent and to make their own decisions wherever possible.

Care records were individual and focused on the needs of that person identifying how people needed to be supported but also acknowledging areas of independence where people did not need support. Detailed daily diaries were kept and evaluated on a monthly basis. This information was then used by the manager to ensure care plans were appropriate to meet people's needs.

Weekly activity plans were in place, which identified a range of things people enjoyed doing. Staff were respectful of people's requests to change these plans and relatives told us people were always out doing something in the community.

Relatives knew how to complain but told us they had never felt the need to do so.

The culture of the service was focused around the needs of the people supported and ensuing they led a fulfilled and happy life, whilst also encouraging independence and the development of skills.

Audits were in place, however the manager stated these were targeted towards residential services rather than supported living and the organisation was reviewing the relevance and appropriateness of them.

You can see what action we told the provider to take at the back of the full version of the report.

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.

Safeguarding was understood and well documented.

Accidents and incidents were well recorded and analysed so strategies and support could be reviewed to minimise the risk of them happening again.

Relatives told us there were always plenty of staff.

Medicines were stored, administered and recorded in a safe way.

Is the service effective?

Requires Improvement

The service was not always effective.

Supervisions were held though not consistently in line with the provider's policy or supervision contracts. Due to this staff said they did not feel supported.

Training was provided and staff had attended specific training to ensure they had the skills and understanding to support people's individual needs.

Mental capacity was understood and people were offered support with decision making.

Is the service caring?

Good

The service was caring. Staff approach was caring and professional.

Staff treated people with respect and dignity, supporting people to make decisions.

Picture symbols were used by staff as detailed in care records.

Is the service responsive?

Good

The service was responsive.

Care plans were specific to the individual and contained information on when people needed support and when they were independent.

People had weekly activity plans but if they chose a different activity this was respected and listened to.

People were supported to plan a weekly menu and then to do the shopping to make sure they had everything they needed and wanted.

Is the service well-led?

Good

The service was well-led.

There was a positive culture and a focus on ensuring people lead active lives and were valued members of their community.

Audits were in place. The manager stated these focused on residential services so they were raising the need for quality assurance systems which were specific to supported living.

Swanton Community Care

Detailed findings

Background to this inspection

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

This inspection took place on 4 and 8 January 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

The inspection team was made up on one adult social care inspector.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. The provider also completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

We also contacted the local authority commissioning team and the safeguarding adult's team who did not raise any concerns.

During the inspection we visited the people living at the service and spoke with three of their relatives. We also spoke with the manager and four care staff.

We reviewed both people's care records and four staff files including recruitment, supervision and training information. We reviewed medicine records for both people, as well as records relating to the management of the service.

Good

Is the service safe?

Our findings

One relative said, "They seem very safe and well looked after."

The manager was aware of safeguarding and how to protect people from abuse and avoidable harm. Staff said, "If I had any concerns I'd go to the manager and I'm sure it would be dealt with." Another staff member said, "I'd report it, there's also a whistleblowing line I could use if I needed to. There was a log in place and information in relation to potential abuse was well recorded and included information on the potential triggers and the action taken by staff. The provider's safeguarding policy was available for staff to refer to. The local authority safeguarding procedure which needed to be followed was easily accessible.

People had pictorial, easy read information in the care records about how to keep safe and how to prevent bullying.

Accident and incident reports were detailed and the action taken by staff was noted as well as the outcome. It was clear that the manager and staff were analysing information for trends and triggers, such as noise levels. Staff used this information to change the way support was provided to ensure incidents did not happen again.

Risk assessments were detailed and included what the potential harm was, whether or not the person was aware of the risk and a risk management plan. The management plan included triggers and warning signs for the risk as well as preventative strategies and how to respond in an emergency. The risk assessment included a section for a risk score which included the likelihood and impact of the risk. We noted this was blank on every risk assessment. The registered manager said, "I think it was because we had difficulty finding how to calculate it. I will deal with it straight away."

Personal emergency evacuation plans were in place as part of people's care records. These informed staff of the support people needed to evacuate the building in an emergency.

A business continuity plan was in place and included action to take in the event of a loss of utilities, heating, water supply as well as catering disruptions and being unable to use the accommodation. A list of emergency contacts was available in the plan.

Staffing levels were set by the commissioners of the service, according to people's assessed needs. Relative's said there were always plenty of staff. One relative said, "There's plenty of staff, [relative] goes out with them all the time." Another relative said, "They easily have two staff each normally." The manager said, "I'm going to discuss staffing at the next MDT as [person] doesn't need two to one staffing, it can draw attention and gives the wrong impression. They don't need it."

There were mixed views from care staff about whether there were enough staff, one staff member said, "No, there's not enough staff, it impacts on work life balance." Another said, "At the minute there's not because we are short staffed but ordinarily there's enough." The other staff we spoke with said there were always

enough staff to meet people's needs. Some agency staff were being used to cover current vacancies but the manager said, "I tend to steer clear due to people needing consistency. It's not the best option. I'm recruiting some relief staff." During the inspection we heard the manager actively seeking to recruit staff on a relief basis so they would be able to get to know people and cover any absence rather than using agency staff.

Recruitment processes included an application form and interview. This was followed by a minimum of two references and a clear Disclosure and Barring Service (DBS) check, before being offered a post. DBS checks help employers make safer recruitment decisions by preventing unsuitable people from working with vulnerable people.

The manager also said, "We try to involve people in recruitment, [person] may come in and meet applicants or sit on the panel. We also try to include relative's views about the things that are important to them." They went on to say, "Everyone would complete their mandatory training before they start, no one shadows without their training." Mandatory training would include, safeguarding, mental capacity, fire training, equality and diversity and food safety amongst others. Once completed staff would then shadow an experienced member of staff until they had been assessed as competent.

Staff attended annual training in medicine management and a medicine competency observation was completed every six months by the manager or team leader. Where staff had not passed the competency observation or where there had been a medicine error, staff were supported to achieve the required standard.

Medicines were stored in individual medicine cupboards inside a locked medicines room. People's photographs were in their medicines files and Medicine Administration Records (MARs) were colour coded for the time of administration. There were no gaps on the MARs which showed that medicines were being appropriately administered and recorded. One staff member said, "I've just done my six monthly competency check for medicines, we are well trained in it."

Care plans for medicines included how care staff should order, store and record medicines, as well as information on how to support the person with taking their medicines. Information was available on the current medicines people had been prescribed, the dosage, route and reason for administration. People had also attended an annual review of their medicines with the doctor.

Requires Improvement

Is the service effective?

Our findings

There were mixed views from staff about the support they received. One staff member said, "I didn't have an induction. I haven't had supervision for a while. It's put on the rota and then it gets cancelled and it isn't rearranged. I've not really had much to do with the manager; I need to see more of them." Supervisions are regular meetings held between staff members and their line manager to give an opportunity to raise any concerns and to hear feedback on performance and training needs. Another staff member said, "I think I've had one supervision but the team are really supportive. I haven't had much to do with the manager, we haven't had a team meeting yet, it was planned but got cancelled and I don't really know why." Other staff said they felt well supported and had regular contact with the manager.

Care staff signed a supervision contract which specified the frequency of supervision would be not less than six per year. It also specified staff responsibilities in terms of engaging in the supervision process.

Care staff had not received supervision sessions, in line with the supervision contracts. The manager said, "I came into post in August and try to do them monthly, or bi-monthly but had to cancel Decembers." Records showed that care staff had all received one supervision in the five months since the new manager came into post.

One staff member said, "We haven't had a team meeting for a while, communication could be improved." The manager said, "Team meetings are held on a monthly basis, but Decembers had been rearranged to January as only two staff had been available to attend. The agenda's in place." The agenda included reviews of care needs, finances, any operational changes, health and safety and training. The minutes of previous meetings were from May 2015 and September 2015. There was no evidence of meetings having been held on a routine basis each month.

Care staff said they needed to have some training in the use of Makaton and picture exchange communication systems (PECS) as people used these ways to communication their needs. The manager said, "We are also looking at Makaton training as people used this as a means to communicate."

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager explained that care staff completed the care certificate which was assessed internally as part of their induction. They added, "I think the organisation are looking into service specific inductions." They explained that new care staff would shadow existing care staff whilst they completed the care certificate, they said there was no set timeframe for this as it depended on their previous experience and knowledge and how the people they were supporting interacted and engaged with them.

The majority of staff had not been in post for a year so appraisals were not yet required as they are completed annually. However, where care staff had transferred from another service they had received an annual appraisal of their performance. Newer staff members had also completed a probationary review

which assessed their competency.

Staff training was up to date, although some of the newer staff needed to complete their training for which dates had been booked. Staff were trained in Non-Abusive Psychological and Physical Intervention (NAPPI) which specialises in British Institute of Learning Disabilities (BILD) managing challenging behaviour training. This has an emphasis on the approaches of Positive Behaviour Support (PBS) when working with people whose behaviour may challenge services. NAPPI includes the principles of positive behaviour support which is both positive and proactive. Positive means increasing and strengthening helpful behaviours through 'reinforcement' (not using punishment or negative consequences to reduce the challenge). Proactive means anticipating where things may go wrong and preventing that from happening rather than just reacting when things go wrong. This gave staff a detailed understanding of people's behaviour and how to implement strategies to support people if they were anxious or distressed.

People's care plans identified how they communicated if they were anxious or unhappy and how staff should respond to best support them. There was a description of how people expressed their anxiety and detailed strategies on how staff should respond. Care staff had also identified particular triggers or situations that the person found distressing and these were recorded together with strategies to use to try to reduce anxiety. Information was available on the type of staff people formed relationships with.

The manager said they had links with the local behaviour therapy team if their input was needed but they did not feel this was required at this time.

The manager was proactive in sourcing specific training so the care staff had the skills they needed to understand people and communicate with them effectively. The team had just completed some specific training around autism which the manager said, "Was helpful to raise people's understanding."

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. One staff member said, "It's all about people's understanding to make decisions and how we support them to make their own decisions."

The supreme court judgement made in 2014 extended the scope of Deprivation of Liberty Safeguards (DoLS). These safeguards are part of the Mental Capacity Act 2005 and are a legal process that is followed to ensure people are looked after in a way that does not inappropriately restrict their freedom. If a person is receiving care in a community based environment, arranged by the local authority, the Court of Protection must authorise any deprivation of liberty. This is
the only route available. Anyone who feels that a deprivation of liberty in this setting may be required can ask the local authority to seek authorisation.

People had appropriate authorisations in place through the Court of Protection and decisions were made in people's best interests.

People were supported to make decisions around maintaining a healthy balanced diet and were encouraged to take part in regular exercise.

Care plans were in place which detailed where people liked to sit for their meal, whether or not they liked people to sit with them and how they planned and chose their meals, including writing shopping lists.

We observed staff offering choice to people at meal times, they said, "We do a menu plan with people on a Sunday night and then do a shopping list. We are trying to get them to try new foods and have new experiences."

The manager said a referral was being made to the Speech and Language Therapy Team (SALT) for one person as they needed support and training with the use of Picture Exchange Communication (PECs) which is a communication system used by one of the people supported.

Records were kept of appointments attended, including the outcome and any changes or action needed. There was also a record in the daily diaries of any further appointments that needed to be arranged.

People had regular appointments with opticians, dentists, doctors, psychiatrists, podiatrists and social workers all of which were recorded. Alongside care plans which detailed the support people needed to attend appointments, such as not attending until the required time as they found waiting difficult.

One person had a hospital passport which included the key things nursing staff may need to know about the person to understand them should they need to attend hospital. The other persons was in progress and due to be completed the week of the inspection,

Good

Is the service caring?

Our findings

One relative said, "They are doing a wonderful job, [relative] seems quite happy." They added, "They are lovely people, the staff are wonderful." Another relative said, "Staff are very caring, [relative] seems to be getting on alright, they have more independence, they seem really happy." Another said, "I am absolutely over the moon, [relative] are so happy, they are singing all the time, which is a really good sign."

We observed staff engaging with people in a caring, compassionate and respectful manner. Their approach was calm and confident yet empowering so people were supported with decision making in a way they understood. Staff were able to explain why they offered two options when supporting someone to decide what they wanted for tea, they said, "We offer two options as they can make a choice between two things."

Another staff member said, "We use picture symbols to show what's happening now and what will happen next. I'll put on that you're here as the visitor and then we'll have tea."

A relative said, "The staff are very conscientious, they deal with things and react well, quickly and professionally."

People had their own sitting room and bedroom which were decorated to their individual tastes. One person's room was very feminine whilst another person's room clearly showed that the person enjoyed using technology. One relative said, "[Relative] and family were involved in decorating their room. They just walked off after a while but that was fine with the staff."

Staff explained they involved people as much as possible by asking questions and knowing if people were happy or not by getting to know their way of communicating.

The manager said, "We want families to be involved in care planning but for various personal reasons it hasn't been the right time for people." They added, "I always run care plans past family members and they sign them. Families are very involved in people's lives; after all they know people best."

Staff said they respected people by ensuring privacy was maintained, by respecting that people sometimes wanted their own space. One staff member said, "I treat them how I would want to be treated, treat them as adults." We observed this happening during our inspection.

The manager said, "No advocates have been identified, we struggled to find one to get involved with the pooled finances arrangement so it was agreed with the care manager, family members and myself."

Information for staff on equality and diversity was available in the staff handbook, this included definitions on how to promote equal rights for everyone.

Good

Is the service responsive?

Our findings

One relative said, "There's nothing that can be done better." Another told us, "Staff know what [person] enjoys and they always make sure they can do it, it's wonderful, they are always out and about in the community."

Staff said they knew people's needs and were getting to know people better each day and learning more about them. They were able to describe people's needs and we observed staff were following care plans when they were supporting people. Staff explained they recorded information and learning in daily diaries, and the information was then used in care planning.

Care records included 'quick information' which detailed the key things to know about each person, such as 'Happy and friendly, sociable and chatting.' This document also included key information about the person's presentation in terms of reassurance and possible risks. There was also a document called 'About me' which gave brief details of the person's history, what was important to them, their likes and dislikes and hopes for the future.

Care plans for one person had been re-written in October 2015 and contained detail on how the person needed, and liked to be supported. They had been reviewed on a monthly basis. The other person's care plans were being finalised following transition to the service. The manager was introducing a new format based on headings such as 'Why I need support, aims and objectives and interventions required.' They explained this would further improve the information on how people needed to be supported and allowed for greater consistency in the support that was offered. They went on to say, "I want the support plans to have enough information in them so you would be able to support the person just by reading the plan."

Information on people's communication needs was integral in the care plans and specified how to communicate with people, their level of understanding, what particular body language or gestures meant and the systems they used to communicate. Examples included saying the person's name first to ensure staff had their attention and using simple and short sentences. In addition people also used assistive technology as an aid to communication, such as Ipads.

Sensory diets had been developed by occupational therapists. A sensory diet details how to support someone to ensure their sensory needs are being met. This involved appropriate touch which was instigated by the person themselves only, ensuring people received vestibular stimulation which relates to movement such as walking and running and proprioceptive stimulation which refers to people's awareness of their body.

Care staff completed daily diaries which were written in a personalised way and included how the person had worked towards their goals and how they were part of a caring community with people they liked and who liked them, this included things like visiting family, or spending time with the staff and the other person they lived with. Information was also recorded on how people had been productive and contributed to their own wellbeing and that of others and completing activities that were fun, enjoyable and held the person to

relax and refocus. There was also space for care staff to record anything else that had happened that day and to record information in relation to medicines, incidents, accidents or appointments.

Diaries were evaluated on a monthly basis and reviewed by the manager. The evaluation included progress towards goals such as developing daily living skills and making decisions around activities. A record was also kept of what worked, or didn't work during the month so this information could be used to review care plans to make sure people's needs were met as effectively as possible. The manager said, "I review them on a monthly basis to look for person centred activities, the support that's needed any health or behavioural issues, interaction and engagement and recording issues."

It was evident through reading people's daily diaries and care plans that people were being supported to participate in the local community and to maintain and develop friendships and relationships in a positive and proactive way to ensure they had a good quality of life.

Rotas showed that people received individual support hours to attend social activities of their choosing or to attend college. Rotas were also personalised so staff knew who they would be supporting on each shift.

One relative said, "They go to college and shopping, discos, bowling they are always out on walks or doing something." It was acknowledged that people benefited from having structure and routine to their day which was planned using a weekly activity plan. Staff explained that if people chose not to do something or wanted to end an activity early this was respected and people's decisions were acted on. People enjoyed a range of activities from going out for meals or to the pub, to spending time with family members, attending college, going for walks, listening to music or watching DVDs and doing jigsaws as well as being supported with shopping, laundry and other household chores.

Relatives said they knew how to complain and one relative said, "I can't fault it, there's nothing to grumble about it." A complaints file was in place which included the complaints policy. This detailed specific actions and timeframes for dealing with complaints. No complaints had been logged. The manager said, "We haven't had any." They went on to say, "We did have one from a neighbour." There was no record of this in the complaints file. However, the staff team had been provided with an update on the outcome of the complaint in the team meeting.

One person had recently transitioned from a different service to Swanton Community Care. A transition plan was in place and there was full involvement from all services, as well as the care management teams and family members. There was ongoing communication between the service and the colleges attended by people to ensure everyone was kept up to date with progress or any concerns.

Good

Is the service well-led?

Our findings

The service had been without a registered manager since September 2015. However, there was a manager in post who was currently completing their registration with the Care Quality Commission, they had been in post since August 2015.

One staff member said, "Things have definitely improved since we've had the new manager, they listen to us and take our views on board."

The manager said the provider was, "Fabulous, supportive. As a new manager I'm listened to and my ideas are taken on board for moving forward." They added, "I feel my opinions are valued from a supported living background so I could transfer my knowledge over which is appreciated by senior managers." They went on to say, "I have regular one to ones with my manager to raise concerns, yes I'm provided with the right training, I want to do a degree in autism but not sure if there's funding for it."

Family and friends' surveys were being prepared to be sent out by the manager on the day of the inspection. This was a forum for seeking relative's views on communication, care planning, activities and whether they thought people's needs were being met, training for staff and it also gave an opportunity for any concerns to be raised. Staff surveys had not yet been completed.

Monthly managers' meetings were held. However, there were no minutes produced or available for viewing. The manager said, "I make my own notes, otherwise there's no point." They explained agenda items included business plans, marketing, training, staff questionnaires, building reputation and trust and business development." They added, "We also do lessons learnt, it's helpful to understand what wasn't right and what's needed to put it right. It's common sense that we need to know our role but it's good to have those sessions."

A governance and quality policy was in place dated April 2015 which detailed the roles and responsibilities of staff and management in relation to quality monitoring.

A manager's spot check visit report had been completed in November 2015 at 7.30pm which had assessed staffing, activities, the atmosphere in the service and a range of observations. They said, "I will be completing them monthly."

The manager also completed monthly governance and quality reports. All information on accident's, incidents and safeguarding's were entered onto this system so the information could be reviewed and commented on by the head office. The last report had been completed in November 2015 and reported on referrals and targets for future referrals. It audited staff documentation such as job descriptions and contracts, as well as reporting on the care hours and management hours provided any safeguarding concerns, and accident and incidents. It also looked at reviews of care plans and risk assessments, medicines audits, staff competencies, complaints and a range of other documentation. Comments were included that personal emergency evacuation plans needed to be completed and we saw that this had been

done. There was no formal action plan attached to the audit. However the manager said, "If there were a number of actions to complete an action plan would be generated."

The monthly manager audits were used by the provider to produce a quarterly governance and quality report which recorded information on the performance of the provider as a whole.

Monthly medicine audits had been completed. These ensured all relevant information was recorded on MAR charts as well as ensuring any missed medicines had been recorded with the use of relevant coding. Any gaps on MARs were investigated and it ensured the care plan and risk assessment for medicine administration was appropriate. No issues had been identified.

A range of additional audits had also been completed in July 2015 such as bedroom audits, housekeeping audits and infection prevention and control. The manager said these hadn't been completed since then because, "They were geared around residential services so were being reviewed to see if they fit with a supported living model." They went on to say, "I'll discuss it at the supported living group." The supported living group is a provider wide group specifically for the managers of the supported living/domiciliary care services so they can discuss best practice and raise issues.

The manager said they completed spot checks, medicine administration audits, monthly quality audits, audits of staff files, and daily diaries on a monthly basis. Care plans and risk assessments were not audited as they were written and reviewed by the manager.

A business plan was in place. This included actions to grow the business, alongside the requirement for autism specific training, which had been delivered. There were plans to develop recruitment and retention, improve recording systems, develop relationships with housing providers and develop the quality systems and internal audits.

The manager said, "I'm looking to introduce some active support to the team in the New Year." Active Support is designed to make sure that people who need support have the chance to be fully involved in their lives and receive the right range and level of support to be successful. This includes support to participate in the full range of activities that everybody else does; to be involved with and share interests with other people and to develop relationships, skills, and experience.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received appropriate support, training and supervision in their role to ensure competence was maintained in line with the providers own policy. Regulation 18(2)(a)