Four Seasons Homes No.4 Limited

Swan House Care Home

Inspection report

Swan Drive
New Road
Chatteris
Cambridgeshire
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Ratings

Overall rating for this service	Good
Is the service well-led?	Good

Overall summary

We carried out an unannounced comprehensive inspection of this service on 14 April 2015. During this inspection a breach of legal requirements was found. This was because the registered person had failed to notify us of incidents they are required by law to tell us about.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach. We undertook a focused inspection on 8 June 2015 to check that they had followed their plan and to confirm that they now met legal requirements.

This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Swan House Care Home' on our website at www.cqc.org.uk'

Swan House Care Home is a two storey building located in the residential area of Chatteris. The home provides accommodation for up to 40 people who require nursing and personal care. At the time of our inspection there were 39 people living at the home. The home is split into four main units where people are cared for according to their assessed care or nursing needs. All bedrooms are for single occupancy.

The home had a registered manager in post. They had been in post since April 2014. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our focused inspection on 8 June 2015, we found that the provider had followed their plan which they had told us would be completed by 15 April 2015 and legal requirements had been met.

Summary of findings

People living in the home were confident that action would be taken if an accident or incident occurred such as a fall, and that these would be reported. Staff had been trained on incident reporting and recording. Arrangements were in place to ensure that where staff deputised for the registered manager, that reporting of events was carried out.

Staff had received additional training regarding the reporting of notifiable incidents including Deprivation of Liberty Safeguards, serious injuries and suspected abuse.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service well-led?

Good

The service was well-led.

Quality assurance monitoring and audits completed by the registered manager and provider ensured that all incidents were recorded and reported where required. The registered persons had notified the Care Quality Commission of incidents that we are required to be informed about by law.

People and staff were effectively supported by the registered manager who kept themselves aware of the culture within the home.

People were supported by a staff team who knew what keeping people safe meant and ensuring that all incidents were reported including falls.

Swan House Care Home

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Swan House on 8 June 2015. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection of 14 April 2015 had been made. The inspector inspected the service against one of the five questions we ask about services: is the service well-led. This is because the service was not meeting legal requirements in relation to The Care Quality Commission (Registration) Regulations 2009.

This unannounced inspection took place on 08 June 2015 and was completed by one inspector.

Before the inspection we looked at the Provider Information Pack. This is information we hold about the service and includes the number of notifications, the provider's improvement plans and a range of information sources including the Provider Information Return. We also looked at statutory notifications that we had received. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with three people living in the home, the registered manager, two nursing staff, one care staff and domestic staff members. We also observed people's care to assist us in understanding the quality of care people received.

We looked at five people's care records. We looked at records in relation to the management of the service such as audit and accident recording systems.

Good

Is the service well-led?

Our findings

At our comprehensive inspection of Swan House on 14 April 2015 we found that registered persons had not always notified the Care Quality Commission about incidents they are required, by law, to do so. This was a breach of Regulation 18 (1) (2) (d) (f) of The Care Quality Commission (Registration) Regulations 2009.

At our focussed inspection on 8 June 2015 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirement of Regulation 18 as described above.

The home had a registered manager in post. They had been in post since April 2014. One person said, "I see the [registered] manager around every few days and they always ask, how I am." From records viewed we found that since our inspection in April 2015 the registered persons had made notifications to us that they are required, by law, to do so. This included reporting of deaths, and an authorised DoLS application. We saw that the provider had displayed our previous inspection rating in a prominent position.

Information and guidance was in place to ensure that in the event of the registered manager's absence, other staff would have the knowledgeable on how to notify the CQC without delay. Staff said that if ever they witnessed any incidents or were made aware of these they would ensure the registered manager was informed. This included events that required urgent attention. Information was passed to the registered manager when they returned from leave. This was to ensure that the registered manager was aware of anything that may then need to be reported. People were assured that if a notifiable incident occurred that the appropriate authorities would be informed.

We saw that following our inspection in April 2015 the registered manager had provided staff with feedback of what they had done well and the areas for improvement. We also saw that robust and effective action had been taken to address those areas we identified as requiring improvement. This included additional training to staff whose role involved reporting notifiable events. In addition, checks and reviews of people's end of life care wishes and the up-to-date records which supported these had been completed.

Quality assurance audits completed by a regional manager now included checks to ensure all incidents were accurately reported. For example, where an under reporting of expected incidents occurred, investigations had taken place to ensure that this was the case rather than staff had not reported these. The registered manager showed us the accident and incident recording system and how each incident was prioritised for action. For example, where urgent action was need or where more routine updates to people's care were required.

All staff we spoke with confirmed that the staff get on well as a team, were supported by a [registered] manager who was open to suggestions no matter how trivial these first appeared. One nursing staff said, "I have worked in other homes but none are as good as this one" and "It is the support and training I get that makes it a good place to work."