Precious Homes Limited

Swan Court

Inspection report

Ashfield Avenue
Birmingham
West Midlands
B14 7AT

Tel: 01217267340
Website: www.precious-homes.co.uk

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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 a residential care home providing personal and nursing care for up to eight people with a learning disability. There were five people living there at the at the time of our visit. Swan court accommodates people in one adapted building, they have their own apartments as well as shared communal spaces.

People's experience of using this service and what we found

Infection prevention procedures were in place but there were some concerns around the monitoring of staff COVID-19 testing and how some staff refusals to be tested were being managed. Staff were recruited safely, and medicines were managed safely. Relatives told us that they felt their loved ones were safe.

Quality assurance checks were in place but had not identified some of the concerns raised during the inspection. The management were responsive to concerns highlighted and some changes were made immediately. Staff and relatives spoke highly of the new registered manager and the deputy manager. Relatives gave mixed views on the outcomes for their loved ones. Most told us they were happy with the care people received. One person told us; "I know that [my relative] is happy, I ask if [they] are happy and [they] say "yes I am happy, I want to stay here." Another relative told us their loved one had made slow progress and may be bored at times but felt that improvements had begun since the new registered manager had joined the service.

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; most of the policies and systems in the service supported this practice.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

This service was able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.
Right support:
• Model of care and setting maximises people's choice, control and independence
Right care:
• Care is person-centred and promotes people's dignity, privacy and human rights
Right culture:

• Ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives

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

Rating at last inspection
The last rating for this service was requires improvement (published February 12, 2020). The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
We received concerns in relation to infection control and about people's care. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.
We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe and well- led sections of this full report. You can see what action we have asked the provider to take at the end of this full report. Although we found risk management around staff testing for Covid-19 to protect people from harm was not robust, at the time of inspection there had been no significant impact on people from this risk.

The overall rating for the service remains 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 a breach in relation to governance systems for infection prevention risks at this inspection. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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.

Is the service well-led?

Requires Improvement

The service was not always well-led.

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave a short period notice of the inspection because some of the people using the service would need support to prepare for our visit.

What we did before the inspection
We reviewed information we had received since the last inspection. We sought feedback from the local authority and Clinical Commissioning Groups. 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 seven members of staff, including a senior manager, the registered manager, the deputy manager and care staff.
We reviewed a range of records. This included two people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records related to protecting people from harm as well as systems used to monitor quality of care were reviewed.

After the inspection –
We spoke with four relatives about their experience of the care provided. We spoke with five care staff. We continued to seek clarification from the provider to validate evidence found. We looked at quality assurance records and further records related to people's care.

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.
The purpose of this inspection was to check a specific concern we had about infection prevention control measures, and concerns about people's care.

Assessing risk, safety monitoring and management; Preventing and controlling infection
● Risks to people's safety were identified but not always managed fully. Systems for monitoring of staff testing for Covid-19 were not always effective. Some staff were not electing to take part in testing in line with the recommended government guidance, the management of the risks they could pose to people was not robust enough. A risk assessment had been completed but did not consider options to remove staff from working directly with people, or how risk reduction methods could be monitored effectively to ensure that staff were protecting people from infection risk.
● A person's fire evacuation plan had not considered all aspects of the plan fully. We spoke to the registered manager about this and it was updated.
● Support plans contained good levels of personal information about people's needs and risks. However, one had not been fully updated to reflect the person's current care needs, the registered manager told us this would be fully updated. Staff did show good knowledge of the person's care needs during the inspection.
● Staff had access to sufficient supplies of personal protective equipment (PPE) including masks, gloves, aprons and hand sanitiser. We saw staff using PPE correctly.
● Staff followed guidelines for donning and doffing of PPE and had an area within the service where this could be done safely.
● Safe arrangements were in place for visitors to the service when it was safe for them to do so. This included Lateral Flow Device (LFD) rapid testing, temperature checks, hand sanitiser and PPE.

Systems and processes to safeguard people from the risk of abuse
● Relatives told us that the service was safe. One person told us "[my relative] is safe there, [the staff] are very vigilant."
● Staff received training in safeguarding and understood their responsibilities if they had concerns about the safety of people using the service.
● Incidents and accidents were recorded and analysed to learn from them and work to prevent further risks to people.
● The provider had appropriate systems in place to safeguard people from abuse. Staff described feeling confident that any concerns they raised would be dealt with appropriately.

Staffing and recruitment

● Staff were recruited safely; appropriate checks were carried out before staff were appointed.
● There were enough staff on duty to keep people safe. Staff and relatives told us they were happy with the levels of staff on duty. One staff member told us; "we have plenty of time to chat and spend time [with people], do activities and support them with daily living skills."
● Staff received appropriate training to support people safely and appropriately.
● During our visit we saw staff were unhurried and taking time to engage in activities with people.

Using medicines safely
● People's medicines were managed safely.
● Medicines administration records showed people received their medicines as prescribed, however some creams were noted not to have a 'opened' date. We spoke to the registered manager about this who assured us that creams would be checked and 'opened' dates would be recorded.
● Care staff received training and competency checks to ensure they were administering medicines safely.

Learning lessons when things go wrong
● Accidents and incidents were recorded and investigated to reduce the risk of them happening again in the future. There were processes in place to share learning with staff.

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.

The purpose of this inspection was to check a specific concern we had about infection prevention control measures, and concerns about people's care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Quality systems within the home were not always robust. Systems to monitor and promote staff testing for Covid-19 in line with government guidance were not always effective. This resulted in staff who were consenting to be tested, not being tested in line with guidance in some cases and posing possible infection risk to people.
- The registered manager had identified that systems to monitor staff testing for Covid-19 required improvement and updated them. However updated systems were still not effective in preventing gaps in staff testing.
- The management had undertaken a range of quality checks and audit processes. However, these had failed to identify some issues raised during the inspection. For example, the provider was aware of a person's ongoing risk which meant that an area of the garden sometimes required immediate cleaning. The provider had failed to implement regular checks and during the inspection the garden area needed urgent cleaning. This posed a possible health and safety risk to the person who could access this area. Daily checks had also failed to note a bin which did not have a lid was being used to dispose of personal protective equipment (PPE), which posed an infection risk to people.
- The registered manager had not identified that the infection prevention policy and procedure required updating to reflect national guidance, although most of the recommendations of the current government guidance had been put into place to limit risk to people.

We found no evidence that people had been harmed however, systems were not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They advised that a more robust system for monitoring of Covid-19 testing for staff had been introduced. The environmental concerns identified during the inspection were addressed immediately.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Relatives gave mixed views on the outcomes achieved for their loved ones. Most people were very happy with the care provided and the progress relatives had made. One relative told us; "[my relative] makes a lot of progress and I have not had any problems with [them]." However, one relative told us they felt more could have been done in a timely fashion to improve outcomes for their loved one, but they had seen improvements with the arrival of the new manager.

● Staff told us that the culture of the service had improved since the new manager had joined in November 2020. One person told us; "yes they are both [the deputy and the manager] very helpful and approachable and fair, they treat everyone equally."

● Staff described a person-centred culture. One staff member told us; "You are providing the level of care tailored to that person, to how they would want it, everything revolves around them, you support them how they want it."

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

● The manager was aware of their responsibility under the duty of candour.

● Relatives told us that they felt confident they would be contacted if needed, they described instances when there had been incidents between people using the service and they had been told by management straight away.

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

● Systems were in place to gather feedback from people and relatives. Feedback surveys were sent to relatives and most relatives described suggestions and requests being acted upon quickly. One relative told us; "if I ask [the deputy manager] for something, [they] will do it, no matter how small."

● Relatives told us that management listened to their concerns and responded appropriately.

● Staff described team meetings as useful and told us about examples of ideas which had arisen in meetings and been used to make positive improvements in the service.

● During the pandemic people had been supported to maintain contact with their loved ones. Telephone, face time calls, and window visits had been arranged. One relative told us; "they have kept us together and we are both happy."

Continuous learning and improving care

● There was evidence of recent improvement and developments in the service and the registered manager showed a commitment to improvement.

● The registered manager took immediate steps to address most of the concerns raised during the inspection.

Working in partnership with others

● Care files and meeting minutes demonstrated that the service was linking with partner agencies.

● Relatives told us that their loved ones were being supported by other professionals where needed.

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
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not developed robust systems to effectively manage safety.

The enforcement action we took:

We served a warning notice and requested an action plan from the provider to monitor improvements in the governance of the service.