Four Seasons Homes No.4 Limited

# Swan House Care Home

## Inspection report

Swan Drive
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## Ratings

| | |
|---|---|
| **Overall rating for this service** | **Good** |
| Is the service safe? | **Good** |
| Is the service effective? | **Good** |
| Is the service caring? | **Good** |
| Is the service responsive? | **Good** |
| Is the service well-led? | **Requires improvement** |

## Overall summary

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 accommodated in single occupancy rooms. The home is split into four main units where people are cared for according to their assessed care or nursing needs.

This unannounced inspection took place on 14 April 2015.

At our previous inspection on 17 June 2013 the provider was meeting all of the regulations that we assessed.

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 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.

# Summary of findings

The provider had a robust recruitment process in place. This ensured that only the right staff were recruited and offered employment.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We found that the registered manager and staff were knowledgeable about when a request for a DoLS would be required. We found that appropriate applications to lawfully deprive some people of their liberty had been submitted to, and authorised by, the local authority (supervisory body). People's ability to make decisions based on their best interests were supported by records to demonstrate where this had been assessed as being lawful.

Staff respected people's dignity. Care was provided by staff in a caring and compassionate way. People's requests for assistance were responded to promptly.

People's care records were regularly reviewed to ensure they were relevant and contained accurate information about people's assessed needs. Support for some people to undertake their hobbies and interests covered a wide spectrum of activities. People were provided with stimulation that was meaningful to them.

People were supported to access a range of health care professionals. This included GP and community nursing services. Risks to people's health were assessed and acted upon according to each person's needs.

People were provided with a choice of meals based upon a range of options including those people who required a soft food diet. There was a sufficient quantity of food and drinks available and people were supported to access these.

People, relatives and staff were provided with information on how to make a complaint and staff knew how to respond to any reported concerns or suggestions. Action was taken to address people's concerns and to prevent any potential for recurrence. The availability and provision of information for Independent Mental Capacity Advocacy (IMCA) services in the home enabled people or their relatives to access these services if required.

The provider had quality assurance processes and procedures, such as audits, in place to improve, if needed, the quality and safety of people's support and care. Five out of six people's end of life records had not been effectively reviewed. In addition, although people had been lawfully deprived of their liberty and safely supported the registered person's had not notified the Commission of these incidents.

We found a breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

# 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 safe?**
The service was safe.

People were supported by sufficient numbers of competent staff.

Checks completed by the registered manager ensured that staff were only offered employment after their suitability to work at the home had been satisfactorily established.

Risk assessments had been completed to help ensure risks to people's health were minimized or eliminated.

Good

**Is the service effective?**
The service was effective.

People's health needs were assessed and met in a way which ensured that these were met by the appropriate health care professional.

Applications and authorisations to lawfully deprive some people of their liberty showed us that staff had a good understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards DoLS.

Sufficient quantities and choices of food and drink were available to people, including those people who required a soft food diet.

Good

**Is the service caring?**
The service was caring.

People were provided with care and support with compassion.

Staff knew what was important to the people they supported. People could be visited at any time without restriction.

People were given every opportunity to maintain and improve their independence.

Good

**Is the service responsive?**
The service was responsive.

People's hobbies, interests and preferred social activities were supported with a wide range of stimulation.

People and their relatives were involved as much as possible in their care assessments. Staff responded promptly to people's assessed needs.

Reviews of people's care helped ensure that changes and improvements were made to their care and support where this was required.

Good

# Summary of findings

**Is the service well-led?**

The service was not always well-led.

The provider's audits had identified areas for improvement including the analysis of accidents and incidents but had not always reviewed people's end of life care records effectively. The registered manager and provider had not always notified the Care Quality Commission of incidents that we are required to be informed about by law.

People and staff were supported by a registered manager who made sure they were available.

People were supported by care staff and non care staff who shared the same beliefs and values of the home about always putting people at the centre of everything they did.

**Requires improvement**

# Swan House Care Home

**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 unannounced inspection took place on 14 April 2015 and was completed one inspector and a GP specialist advisor. This is someone who has specialist knowledge of GP services and people who receive these services.

Before the inspection, the provider 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 improvements they plan to make. We also looked at information we held about the service including statutory notifications. A notification is information about important events which the provider is required to tell us about by law. We also spoke with the service's commissioners, the local safeguarding authority and received information from the home's community nurses.

During the inspection we spoke with 12 people living in the home, six relatives, the registered manager, two nursing staff, four care staff, the chef and two non care staff members. We also observed people's care to assist us in understanding the quality of care people received.

We looked at six people's care records, people who use the service (residents') and relatives' and staff meeting minutes and medicine administration records. We looked at records in relation to the management of the service such as checks on the home's utility services. We also looked at staff recruitment, supervision and appraisal processes records, and training planning records, complaint and quality assurance records.

Good

# Is the service safe?

## Our findings

People told us that they were safe living at the home. One person said, "All your needs are met." They also said that they would speak to the [registered] manager, nurses or senior care staff management if they had concerns about their safety. Another person said, "The reason I feel safe is that staff are always there when you need them." People, relatives and visitors told us that there was sufficient staff on duty. This was confirmed by our observations during this visit. A staff member said, "There are times when it gets very busy, especially if staff ring in sick but we help each other out."

People told us that they were able to take risks including going out alone, going to the shops, pubs and other local amenities. One person said, "I go out to get a newspaper or do a bit of shopping, but the staff make sure I have all my equipment with me in case I need help." We found that

risk assessments had been completed and reviewed by staff to ensure that any risks to people were reduced or eliminated. One relative said, "[Family member] used to be vulnerable living at home but now they are here it is reassuring to know that if they had a fall that someone would be there for them."

Staff we spoke with, including non care staff, had received training on how to protect people from harm and who concerns could be reported to. They explained to us what the signs of potential abuse could be and also what action they would take if they became aware of anything of concern. Staff were also aware of the whistle-blowing policy and said that they had no reservations in reporting any incidents of poor care practice, if needed. Information was displayed in the home about protecting people from harm and a service user guide supported people in reporting anything that worried them. One person told us, "I go out and sign out and back in so that staff know where I am." This showed us that the provider took steps to help ensure people were kept as safe as possible.

The provider had not notified the CQC of all incidents involving people's safety but had taken appropriate steps to ensure people's safety. Examples of this included the movement of people to more appropriate services where people's behaviours could no longer be safely managed in the home's environment.

We found that all medicines were stored correctly and securely. Staff's competency to administer people's medicines was regularly assessed after they had been trained. This was to ensure that staff maintained a thorough understanding of safe medicines administration. Records of the quantities of medicines held matched the records we looked at. Staff had access to, and used, clear guidance and instructions to ensure people were administered their prescribed medicines at the time they needed. We saw that the morning medicines administration round had been completed by 10.00am to support people in a timely way. Other daily administration times were spaced according to people's prescribed medication timings.

Staff told us about their recruitment and induction to the service and records showed us there was an effective recruitment process in place. This was to ensure that the provider only offered staff permanent employment after appropriate checks had been completed. Checks included those for any unacceptable criminal records (Disclosure and Barring Service), written references from staff's previous employers and explanations for any gaps in employment history. Other evidence included that for nursing staff who had maintained their professional registration with the Nursing and Midwifery Council (NMC). This included nurses maintaining knowledge about current nursing practices.

During our inspection we noted that the activation of people's call bells was responded to within a few minutes. Staff were seen supporting people with their safety including moving and handling with equipment which had been checked and serviced correctly. One person said, "If they [staff] are busy when you call they tell you they will just be a few minutes which is reassuring." The registered manager and senior care staff explained how people's care and support needs were assessed before they moved into the home. This assessment was then used to form the basis upon which each person's care was provided and helped determine a safe level of staffing for each person.

Where people had been identified as being at an increased risk due to their health conditions we found appropriate steps had been taken. These included regular turns to prevent a skin pressure area developing and monitoring of people's food and fluid intake where required. Other examples of action taken included falls protection mats,

Good

# Is the service safe?

equipment that highlighted to staff if a person had got out of bed and additional checks of people's well-being. This was to help ensure that people's health risks were effectively and safely managed.

Periodic and regular checks had been completed on the home's utility systems, equipment and environmental health and fire safety. Staff told us about various fire alarm tests and practices. Each person's care plan detailed the support they need in the event of an emergency such as a fire. People were assured that the provider had appropriate checks and procedures in place to help ensure their safety.

Good

# Is the service effective?

## Our findings

All of the people we spoke with told us that staff appeared competent and confident in providing people's care. One person said, "I was a bit nervous when I moved in but now I totally trust the staff. They are all very good at predicting what I need help with." Another person said, "Since moving in I have become more independent and this is down to the staff helping me."

People's care plans included advanced directives including do not attempt cardio pulmonary resuscitation (DNACPR) records which had been signed by a health care professional and discussed with the person or their families. Staff told us and explained when this decision was to be respected.

During the lunch time people were supported to eat in the dining area, in their room or a place of their choice. We saw that food was served promptly and staff kept people informed of what they had chosen and of the other options available. One person said, "The food is very good. We get choices each day and we can change our minds. I only eat certain foods and they make sure I get these." People told us, and we saw, that they had snacks and drinks during the day and that staff ensured that there was always plenty of food and drinks available. A relative told us, "Whenever I visit, which is frequently [family member] always has a drink in their room or on their table and staff are always popping in to check."

Where people had been identified as being at an increased risk of malnutrition, we saw that they were supported by an appropriate diet and that monitoring arrangements were in place. In addition, other checks such as regular weight monitoring had been completed to ensure people at risk were being effectively supported. We were told by community nurses supporting people with their eating and drinking that the staff sought assistance as soon as a person was at risk. This was done very promptly if a person was not maintaining a healthy weight or had other swallowing difficulties. This showed us that the registered manager took steps to ensure people ate and drank in a way which met their needs.

One person told us, "I am a vegetarian. I like certain foods and there is always plenty of these provided. I never go wanting." We saw and people told us there was a choice of meals each day including puddings. A relative said, "When [family member] came to live here we provided a list of their favourite foods as [family member] can't do this for themselves." This meant that people and their relatives were involved in the decisions about what people preferred and were offered to eat.

The registered manager and staff told us that they received regular supervision and support to ensure they were kept up-to-date with current care practices. One staff member said, "It is a while since my induction but I was supported until I was confident doing things on my own. I get offered lots of training and opportunities to gain health care related qualifications." The training planning records we looked at and staff we spoke with, confirmed that staff had regular and refresher training. The registered manager, senior care and nursing staff told us that they also regularly offered and gave day to day support. The registered manager kept themselves aware of staff's training needs and attendance and took appropriate action if staff did not attend their training.

We saw that staff understood people's needs well. This was by ensuring they always received an appropriate consent from each person before providing any care or support. We saw and one care staff said that, "Before entering a room I always knock and wait for permission to enter." Another care staff said, "Some people use sign language to convey their agreement or refusal of care." The registered manager explained how people were supported in the least restrictive way possible and all possible options were considered. Examples included assistive technology (pressure sensing mats) to alert staff to people's movements. This meant that people were able to safely get out of bed and were not unnecessarily restricted.

We found that the registered manager had sought and gained authorisation from the appropriate authorities (Supervisory body) to lawfully deprive some people of their liberty. This was to ensure people were cared for in a safe way without exposing them to unnecessary risks that were not in their best interests. This showed us that staff, appropriate to their role, had a good understanding about what the implications of the MCA and DoLS meant for each person. We found that where people required care that was in their best interests but they did not have capacity to agree, the necessary steps had been taken to ensure that this was done in a lawful way.

People told us, and we saw, that access to a range of health care professionals including speech and language

Good

# Is the service effective?

therapists, opticians, podiatrists and GP services were available and provided when needed. One relative said, "I am always kept informed about [family member]. They tell me what's happened, what action has been taken and if any medicines have been started or stopped." Another relative said, "This home came at the top of my list for [family member] as I had heard from friends how well people were cared for with many health conditions."

People's health conditions were monitored regularly and where health care support was required we saw that referrals were made in a timely way. A community nurse said, "Staff actively call me should they have any concerns to enable a review of people's support and to provide a plan of action." This showed us that people's health care needs were attended to.

Good

# Is the service caring?

## Our findings

People and their relatives told us that the staff were caring, sensitive to their needs and provided compassionate care. One person said, "The staff are all very good at recognising if I am not happy and are quick to cheer me up." A relative said, "When [family member] arrived they were not independently mobile but now they go everywhere in the home with their walking aid." Another relative told us, "I like to help care for my [family member] but if am not here staff still do everything."

People were supported at meal times, with their personal care and with things that were important to them according to their assessed needs. This was aided by information in people's care plans and staff's knowledge of people's life histories. The registered manager told us that during reviews of care and talking about matters of interest, people sometimes tell you the most amazing things about their lives." They told us that this information was then used to ensure people's care was appropriate.

People's rooms were personalised and included flowers and information which people found helpful. Throughout the day we saw that people's needs were attended to in a way which respected people's dignity. This was by closing doors, curtains and using towels to cover people during the provision of their personal care. Staff told us that by talking and having a joke with people it was possible to reduce people's anxieties and still show dignity in providing intimate care. People's care plans contained sufficient detail and guidance so that staff, especially newer staff, had the information they needed to provide people's care in an individualised way. This included their personal life history and preferences such as whether people preferred a bath or shower.

People's privacy was respected. People who wanted to lock their door were able to do this or they could leave it open if they preferred. One relative said, "The reason I helped [family member] choose this home was for the very reason that people were allowed to have their door open or closed." People told us that they could choose when they got up or went to bed, the clothes they wore and that they could access all areas of the home including going out into the gardens.

People were supported to access the equipment they needed to support their independence and mobility in and around the home. This included wheelchairs and walking frames. Staff supported people in a sensitive way including giving people time to complete their chosen activities. We saw that throughout the day staff offered people encouragement to help maintain and improve their independence.

People, their relatives or friends were involved in the reviews of the care provided. One visitor told us, "I have known [name of person] for a long time and as they are unable to speak up for themselves the [registered] manager is always asking us if everything is alright or if there is anything they could improve." People and relatives told us how they were kept informed about GPs' visits or hospital appointments affecting their family members care and of any changes such as to prescribed medicines or things which affected people's health. One person said, "I see my GP every week. At the last visit I was pronounced well."

Information regarding advocacy services was available in the home for people who lacked capacity. The registered manager told us that people or their relatives were able to request general advocacy services if this was required and advocacy was sought where there were no surviving relatives. This meant that people were supported to access services when they needed someone to 'speak up' for them.

People were able to see and be seen by their relatives at any time. One relative told us, "I visit [family member] regularly and I am always warmly welcomed and normally with a cup of tea." One person said, "It's nice to have relatives visit especially when it's a surprise to me."

Good

# Is the service responsive?

## Our findings

A detailed assessment of people's needs was undertaken prior to them living at the home. This was to ensure that the staff and registered manager were able to provide the nursing and personal care that people needed. A relative told us, "I have never had to raise any complaints at all. The [registered] manager and staff ask how [family member] is regularly if anything needs changing."

One person told us, "I like horses and couldn't believe it when a horse was brought into the home. I was really surprised." Another person said, "There is lots going on. Yesterday there was 1940's reminiscence event and there was lot of things I remembered." We saw that people were supported by staff who were enthusiastic in meeting people's assessed needs including their hobbies and interests. People, including those with visual impairments, were also supported with their interests including electronic devices which helped them in doing crosswords, games and puzzles. Staff told us that they didn't have loads of time to spend with people, but even having a few minutes to sit and talk with people was possible. Other non-care staff said, "When I am in people's rooms it is good just to chat whilst doing my job." One relative said, "[Family member] likes gardening and the staff helped them to create their own garden outside their room and this means a lot."

We were told that a visiting library service was provided and a choice of books was made available according to people's needs. This also included large print or audio options if these were requested. People were supported to follow their beliefs and attended religious services which were held in the home and in the community. Other planned activities included supporting people to vote at the local polling office if they wanted this. People were supported to maintain an active life style with things that were important to them.

People and relatives told us that staff regularly asked if there was anything bothering them and if they were happy. One person said, "I couldn't ask for anything more or better than living here." A relative said, "I have never had cause to complain but if I ever did I would just speak to [name of registered manager]." Staff told us, and we saw in meeting minutes we looked at, that they were able to voice their opinions at staff meetings and that any concerns raised were acted upon.

The provider had up-to-date complaints policies and procedures on display and people were given information on how they could comment about the service, raise concerns or make compliments. This included an electronic means of providing feedback from visitors, relatives and health care professionals which the provider had access to. This helped support responses in a proactive way before any concerns became a complaint. People told us that staff gave them opportunities to raise concerns about their care and action was taken where required. This was during the provision of care and also at formal monthly reviews where staff who were the lead care worker for that person spent time seeking their views and putting measures in place if changes were needed. For example, where medications had stopped or started. People told us that they generally saw the registered manager walking around the home. One said, "I know who they are as I can go and see them in their office for a chat if they aren't too busy."

The record of complaints demonstrated that people's concerns and complaints were investigated and responded to. This was to the satisfaction of the complainant. There were no identified trends or themes as to the nature of the complaints. This told us that people's concerns were not of a general nature.

Requires improvement

# Is the service well-led?

## Our findings

The home had a registered manager in post. They had been in post since April 2014. From records viewed we found they had not always notified the Care Quality Commission of incidents and events they are required to tell us about using notifications. A notification is information about important events the provider must tell us about, by law, submitted to the CQC. This included an incident involving the police. In addition, a DoLS application had been authorised by the supervisory body in January 2015 and again the registered manager and provider had not notified the CQC without delay about these notifiable events. In addition, audits completed by the provider had also failed to identify this omission.

This was a breach of regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

Audits completed by the provider and registered manager had not identified effectively that people's end of life records were not up-to-date. Resuscitation Council UK guidance advises that the person's full name and address should be recorded. The decision should be reviewed whenever clinically appropriate or whenever the person is transferred from one healthcare setting to another or admitted from home. In five out of six people's records we saw, we found that the person's address was not correct and that reviews of people living at Swan House Care Home and their decisions had not been effectively reviewed. This showed us that the provider's audits were not always effective.

People and relatives we spoke with told us they knew the staff who were in charge or how to contact them. They also said that they had a presence around the home on most days. Staff told us that the registered manager also called in unexpectedly to check on people including working a shift with staff. The registered manager told us that this was also to make sure that staff cared for people and supported them to an acceptable standard. As well as keeping themselves aware of the culture within the home. One person said, "I go to see the [name of registered manager] and we talk about all sorts. It's nice to know there is someone so approachable." Staff told us that the registered manager was always there for them whatever time of day or night.

The registered manager attended the Cambridgeshire County Council Registered Managers forum where they were kept up-to-date with social care and CQC requirements. They told us, and this was confirmed in the PIR we were sent, that this was an excellent opportunity to share ideas and best practice. The registered manager told us and we saw that links had been made with the local community including visiting schools choirs, engagement with local charities and Scout groups to provide various support in the home.

Quality assurance checks completed by the provider in November 2014 and March 2015 had identified that various improvements were required. The registered manager showed us the action plan and the dates actions had been, or were due to be, completed. This included actions for staff completing records on people's ability to make specific decisions and the introduction of pain management care plans. We saw that these had been completed in the records we looked at.

We found that people's care records and staff personal information was held securely and confidentially and that access to these was controlled by staff and the registered manager.

All staff we spoke with confirmed that they liked working at the home and the reason for this was, "It's a team that works well together and if upstairs' staff or downstairs are struggling we all pitch in to help. It has been better since an extra member of staff was employed at night." Another staff member said, "It's not just us. It's people as well we are all one big team really."

Records we looked at and staff we spoke with confirmed that regular checks and audits were completed. This was for various subjects including people's medicines administration, care records, and accidents and incidents. The provider's incident and accident recording system was used to determine the number and pattern of incidents. This information was then used to develop and put action plans in place to prevent or reduce the potential for recurrence. For example, we saw that the provider was auditing against the same standards used by the CQC in order that the service could determine how safe, effective, caring, responsive and well-led it was.

Staff meeting minutes we looked at showed us that staff had the opportunity to raise any suggestions to improve the service and that these were acted on. Staff were aware

Requires improvement

# Is the service well-led?

of their roles and responsibilities and how to escalate any issues to the registered manager or provider if required. The registered manager also provided staff with a monthly newsletter which contained information and reminders to staff on the standards of care that were expected. Subjects covered included staffing levels, when supervisions and appraisals were due and deputy management arrangements to cover when the registered manager was absent.

People and relatives were provided with a variety of ways that they could comment about the quality of the care provided. One person said, "I meet and talk with senior staff monthly I think and we go through what I am happy with and the things I may wish to change." It's my choice." A relative told us, "[Family member] has been here a few months now and they are settled. The staff could not have been more helpful in meeting their requests.

The registered manager and staff we spoke with all told us that they would have no hesitation, if ever they identified or suspected poor care standards. This was by whistle blowing (whistle-blowing occurs when an employee raises a concern about a dangerous, illegal or improper activity that they become aware of through work) to the provider's management and the appropriate authorities including the CQC. One staff member said, "I have reported things in the past and action was taken to prevent the situation from happening again. I am now confident that the registered manager would support me."

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where legal requirements 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 |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents<br><br>**The registered persons had not always notified the Care Quality Commission about incidents they are required, by law, to do so.**<br><br>Regulation 18 (1) (2) (f). (4) (a) (b). |