Raphael Medical Centre Limited (The)

Swanborough Services

Inspection report

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Date of inspection visit: 18 September 2015
Date of publication: 10/11/2015

Ratings

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

Overall summary

This inspection took place on 18 September 2015 and was an announced inspection.

Swanborough Services is a domiciliary home care service offering personal care to approximately 41 people who have neuro-disabilities, or an acquired brain injury (ABI) in their own homes, and also to those living within several supported living environments.

The service is required to have a registered manager. 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. At the time of the inspection the service had been without a registered manager for five months. There was an interim manager responsible for the day to day running of the service.

People's safety was being compromised in a number of areas. Care plans and risk assessments were out of date an did not routinely reflect people's assessed level of care

Summary of findings

needs, and some lacked detail to guide staff in keeping people safe. There was no evidence that people were regularly involved in their care planning, or were formally able to give feedback about the service.

Risk assessments, including responding to emergencies and risks to the business, such as business continuity plans were not in place.

There were not enough staff employed to ensure people's safety and that their needs were met. Feedback from staff was overwhelming that they felt under pressure due to staffing levels. One member of staff told us, "We are short of care staff. We will all work as hard as we can, but it can only be so much. It's really difficult to cover all the calls. Staff are starting to go off sick now". The service was in the process of giving notice on several packages of care as they could not ensure that the care could be delivered safely.

Staff rotas were designed for the needs of the service rather than the individual. They contained no provision of travel time for staff to travel between calls, and it was not possible for care workers to get to care visits on time. One member of staff said, "They don't even consider travel time when they are setting up the rotas, you just have to turn up when you can. We'll have one call that ends at 7:30am and the next one is scheduled to start at 7:30am and there is no time built in to travel in between. They also don't factor in the traffic or rush hour".

Quality monitoring of the service was not robust. Although some informal systems of quality assurance were in place, the service did not carry out any formal systems of quality monitoring, such as audits to assess quality and drive improvements. Policy and procedure documentation was not routinely relevant to the service.

The culture and values of the provider were not embedded into every day care practice. Staff we spoke with did not have a strong understanding of the vision of the service. Feedback from staff was not positive and indicated that there was a lack of cohesion and a negative culture in the service. One member of staff said, "At the moment it's the most unstable it's ever been here. I'm not happy in my job".

Where people lacked mental capacity to make specific decisions, the service was guided by the principles of the Mental Capacity Act 2005 (MCA) to ensure any decisions were made in the person's best interests. However, despite some senior staff having appropriate training and knowledge, we found that care staff had not received formal training around the MCA.

Medicines were managed safely and people received the support they required from staff. There were systems in place to ensure that medicines were administered and reviewed appropriately.

Staff were recruited safely through appropriate recruitment practices, and received an induction, basic training and additional specialist training specific to the needs of people. Staff had group and one to one meetings which were held regularly, in order for them to discuss their role and share any information or concerns.

If needed, people were supported with their food and drink and this was monitored. Where people required assistance from healthcare services, the service acted quickly to ensure the person received the care and support they required.

People and their family members told us they were supported by kind and caring staff. They knew how to raise concerns or complaints and felt they would be listened to and acted upon.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of this 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?

Requires improvement 

Swanborough Services was not consistently safe.

Risk assessments intended to keep people safe were out of date, and did not include sufficient guidance for staff to provide safe care.

There were not enough staff employed to ensure people's safety and that their needs were met.

Staff had received training in safeguarding and knew how to recognise abuse. Medication was administered and recorded safely and staff were recruited appropriately to ensure they were suitable to work within the care sector.

Is the service effective?

Requires improvement 

The service was not consistently effective.

Care staff had an understanding around obtaining consent from people, but had not had any formal training around the Mental Capacity Act 2005 (MCA), and what they were required to do if someone lacked the capacity to understand a decision that needed to be made about their life.

People were supported to eat and drink enough and they were enabled to access health services when necessary.

Care staff had completed training and it was refreshed regularly. Staff had opportunities to gain further qualifications and develop their knowledge. The service tried to match staff with similar interests to people.

Is the service caring?

Good 

The service was caring.

People felt they were supported by caring and compassionate staff.

Staff knew the care and support needs of people well and took an interest in people and their families to provide individual personal care. Staff were able to give us examples of how they protected people's dignity and treated them with respect.

Staff were also able to explain the importance of confidentiality, so that people's privacy was protected. Care records were maintained safely and people's information kept confidentially.

Is the service responsive?

Requires improvement 

The service was not consistently responsive.

Care plans were out of date and contained inadequate information to ensure people received care which was personalised to them.

Summary of findings

People did not routinely have their individual needs met in a timely manner. Staff rotas contained no travel time and staff were regularly late for calls.

People told us that they knew how to make a complaint if they were unhappy with the service. Where complaints or concerns had arisen an investigation and action had taken place.

Is the service well-led?

Requires improvement

The service was not consistently well-led.

Quality monitoring of the service was not robust. Although some informal systems of quality checking were in place, the service did not carry out any formal systems of quality assurance. Policy and procedural documentation was not specific to the service.

Staff felt that on the whole they were supported by management and understood what was expected of them. However, feedback we received from staff indicated dissatisfaction with working at the service, and a negative culture.

Swanborough Services

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 was announced and took place on 18 September 2015. The provider was given notice, because the location provides a domiciliary care service and we needed to be sure that senior staff would be available in the office to assist with the inspection. The inspection was undertaken by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We spoke with nine people who used the service and family members on the telephone. We spoke with two people in their homes where the received a supported living service. We also spoke with the interim manager, the deputy manager, the office administrator, the health and safety officer and six care staff. We looked at ten people's care records, and other records relating to the management of the service, including the staff rota, meeting minutes, staff files and policy and procedure documentation.

On this occasion we did not request the provider to complete a Provider Information Request (PIR) because we completed the inspection earlier than originally planned. A PIR 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.

Before the inspection, we looked at notifications we had received from the service. Services tell us about important events relating to the service they provide by sending us a notification. We also spoke with the local authority quality monitoring and safeguarding teams who raised concerns with us about the service.

This is our first inspection of Swanborough Services.

Requires improvement

Is the service safe?

Our findings

People said they felt safe and staff made them feel comfortable. One person told us, "None of my care workers are abusive". However, we saw areas of practice that were not safe.

There was a system in place to identify risks and protect people from harm. Each person's care plan had individual risk assessments in place, which covered areas such as mobility, moving and handling, medication, food and drink, skin integrity and risks in the home environment. They looked at the identified risk and included a plan of action. However, many risk assessments were out of date, incomplete and did not include sufficient guidance for care staff to provide safe care. For example, one person had been assessed on 8 December 2014 as being at high risk of pressure damage. Additionally this person required two care workers to hoist them four times per day due to their mobility. Their pressure care and moving and handling risk assessments were not completed, did not fully describe the risk, and did not contain appropriate information for staff to be able to control the risks, or what actions to put in place if the risks occurred. Another person was assessed as being at high risk, due to their behaviour which could sometimes challenge others. This had been assessed on 11 February 2015 and was required to be reviewed in May 2015 to ensure that the information was still correct and relevant for this person and staff. This had not been done, which placed staff at risk of not being able to manage the risks appropriately, due to having information that was out of date.

A further six of the care files we looked at contained risk assessments that were out of date, or did not have adequate information recorded to enable staff to manage the risk people appropriately. The interim manager told us that the reviewing of risk assessments and care plans had not routinely been taking place, they said, "Up to date risk assessments are in place for about 15 clients, the rest have not been done yet. We are in the process of updating everything, but we needed to stabilise the care delivery first". We reviewed two peoples care files that had been reviewed and saw these risk assessments were up to date and had been completed appropriately.

Formal systems were not in place to assess wider risk and respond to emergencies, such as extreme weather, or situations whereby the office could not be used. We were told by the interim manager that the service operated an out of hours on-call facility within the organisation, which people and staff could ring for any support and guidance needed. However, there was no formal business continuity plan in place for staff to access, should they need instruction on what to do in the event of the service not being able to function normally. We spoke with the health and safety officer, who told us that no specific business continuity plan was in place for Swanborough Services and that they were looking to implement a plan shortly.

People were placed at risk, as the risks to people's health and safety during any care and treatment were not current and did not routinely reflect peoples' needs. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told staffing levels were determined by the number of people using the service and their needs. We found that there were insufficient staff to ensure care visits were routinely completed in full. The interim manager told us, "We are short staffed by about three people at the moment. The current staff are working above and beyond and the calls are being covered. Retention of staff has been a problem, but we are addressing that by explaining to new staff what the role involves". They added, "When we need emergency cover, we ring round to staff who are on their day off and try to get them to cover. Otherwise, the calls are covered by the office staff who are all trained in care work".

We asked staff if they felt that the service had enough staff to meet the needs of people. One member of staff told us, "My priority is always the safety of the clients, but it's been a strain on us staffing-wise, it's very tight. We feel that we need more staff as it impacts on the clients. Sometimes it's manageable, but it's a real struggle if any extra care needs to happen". Another said, "We are short of care staff. We will all work as hard as we can, but it can only be so much. It's really difficult to cover all the calls. Staff are starting to go off sick now". Two further members of staff added, "I'm really fed up, it's just getting silly. You've got care workers doing 13 or 14 hour days, they are just so tired. I did a 17 hour day recently" and "We lose staff all the time because it's such a struggle to get the calls done. Everything is just rush, rush, we're so short staffed".

The interim manager explained further that they had given notice on approximately five people's care packages, due to staffing issues and not being able to ensure that the care could continue to be delivered safely.

Requires improvement

Is the service safe?

Despite evidence that care calls were currently being covered by existing staff, the ongoing situation of staff being required to continually take on extra calls and work longer hours cannot be considered sustainable, and placed people at risk of receiving late calls or missed calls, or having their care package cancelled altogether by the provider. Understaffing impacts on the quality of care that staff can deliver, and compounds the pressure staff have with meeting the needs of people with higher dependency and more complex needs.

There were not always sufficient numbers of staff to safely support people's care needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff described different types of abuse and what action they would take if they suspected abuse had taken place. There were a number of policies to ensure staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people from abuse. Records confirmed staff had received safeguarding training as part of their essential training at induction and that this was refreshed when required.

Safe recruitment practices were followed when they employed new staff. All records we checked held the required documentation. Checks had been carried out by the provider to ensure that potential new staff had no record of offences that could affect their suitability to work with vulnerable adults.

We looked at the management of medicines. Care workers were trained in the administration of medicines. The interim manager described how staff completed the medication administration records (MAR) and we saw these were accurate.

Requires improvement

Is the service effective?

Our findings

People told us they received effective care and their care needs were met. One person told us, "The staff really help me. They help me to keep it all together and make sure I don't get all hyped up". However, we found areas of practice that required improvement.

The Mental Capacity Act (MCA) 2005 was designed to protect and restore power to those people who lack capacity and are unable to make specific decisions for themselves. The interim manager understood the principles of the Mental Capacity Act 2005 (MCA) and gave us examples of how they would follow appropriate procedures in practice. There were also procedures in place for the service to follow to assess people's capacity, and details were available to access professional assistance, should an assessment of capacity be required. Staff were aware any decisions made for people who lacked capacity had to be in their best interests. Staff understood the importance of gaining consent from people before providing care, whilst also respecting people's right to refuse consent. One staff member told us, "I understand about consent and the MCA from my previous roles at other organisations, but I've not had training here". Another told us, "I would always ask first and make sure it was alright before I carried out any care". However, despite staff having an understanding of obtaining consent, we found that care staff had not received formal training around the MCA. This is a risk, as staff may not have clarification about the actions they can take if someone does lack capacity, and the legal safeguards that govern this. We raised this with the interim manager and saw that three senior staff had received formal training around the MCA. During the inspection, the interim manager scheduled a training session for staff around the MCA. However, this has been identified as an area of practice that needs improvement.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely.

The interim manager had a good working knowledge of the Deprivation of Liberty Safeguards (DoLS). Although DoLS does not apply in a domiciliary care or supported living setting, the principles apply, but any authorisations for restrictions would go through the Court of Protection.

Most people told us that they were matched with care workers they were compatible with. If they felt a care worker was not suited to them, on the whole they were able to change them. One person told us that they did not want a male care worker and this was respected. Another person told us they preferred younger staff visited them. The interim manager told us, "When new workers are shadowing, we get feedback from people as to whether they think they will be suitable to support them". One care worker told us "[Person] used to be a musician, and I'm really into music, so we have a good rapport around the Rolling Stones and Billy Joel". We saw records that confirmed where people were not happy with their care worker, then efforts had been made to send an alternative member of staff.

We discussed the communication skills of care workers and communication methods in place to ensure that staff were able to communicate effectively with people. The interim manager told us, "For any new staff, we assess at interview their English language skills, and we continue to assess this at spot checks. We have one person who does not speak English, so we have set staff to attend to their calls, as we know they can understand them". They added, "We use other methods of communication as well, one person uses picture cards as they can't read and others have wipe clean charts to communicate with. We also make use of specific manuals for staff to follow around particular tasks for people". One person told us, "At the moment I have care workers from Romania and Slovakia. I have discussions with a few of them that speak French and I can have a proper conversation with them. They always respond to my wishes and we get on with each other".

Staff had received training which assisted them to provide effective care, for example in food hygiene, manual handling, medication, first aid, health and safety and equality and diversity. Staff completed an induction when they started working at the service and 'shadowed' experience members of staff until they were deemed competent to work unsupervised. They also received training that was specific to the needs of people, for example around the care of people who experienced

Requires improvement

Is the service effective?

seizures and those that have behaviour that challenges. People felt staff were well trained. One person told us, "I've no qualms about their training. I think they are excellent". Staff received ongoing support and professional development to assist them in their role. We saw copies of supervision records and staff we spoke with confirmed they received supervision and appreciated the opportunity to discuss their role and any concerns.

Where required, staff supported people to eat and drink and maintain a healthy diet. The interim manager told us "At pre-assessment we discuss people's choices around food and drink and their shopping. We put in specific calls to assist people with breakfast, lunch and tea. Staff will monitor what people eat and drink if they are diabetic, and we have charts to monitor food and fluid, but we currently have nobody that requires that".

People had been supported to maintain good health and have ongoing healthcare support. One person told us, "If I'm not doing too well, they ask me if I'm alright. They know me and my health conditions". We spoke with staff about how they would react if someone's health or support needs changed. One told us, "I know my clients pretty well. If I thought they weren't well, I'd contact the GP or an ambulance". The interim manager told us, "Staff would recognise when people were poorly. We had a client who was looking grey and saying they were hot. The care worker felt them and they were cold, so they contacted the GP. They had a UTI (urinary tract infection) and needed antibiotics". They added, "Staff are in close contact with GP's with regard to palliative care. We also liaise well with district nurses around pressure damage and the monitoring of this". We also saw that if people needed to visit a health professional, such as a dentist or an optician, then a member of staff would support them.

Good

Is the service caring?

Our findings

People were supported with kindness and compassion. People told us caring relationships had developed with staff who supported them. People we spoke with thought they were well cared for and treated with respect and dignity, and had their privacy respected. One person told us, "I really get on very well with them. They're all very friendly and polite". Another said, "They are really nice and polite". A further person added, "I'm happy with them. We all respect each other".

People told us that they were treated with dignity and respect and their privacy was protected. One person told us, "Yes they are [respectful], they are careful with my belongings. If they spill anything, they immediately mop it up, nothing is left or neglected". Another said, "Yes indeed, they always do [maintain privacy], the electrician came in the other day and the carer covered me with a towel. They are very good like that". A further person added, "They help me get showered and have a cup of coffee. They're never rude to me or anything like that. They're really quite nice".

The interim manager told us that staff had received training in how to respect people's privacy and dignity, they said, "The staff get specific training and we explain to them that the client is the priority. The staff are very caring". Staff told us they had built up good relationships with people. One member of staff said, "The majority of clients love the carers who are going in to them. We build up a good rapport. Carers are always willing to go the extra mile". Another added, "Some clients are really grateful, they are really happy. I like all the clients". We were also given an example of how a care worker makes time to walk a person's dog, as they were unable to do this themselves. The interim manager also told us that people were given choice in the way their care was delivered. They said, "We give people choice around their care calls, for example, do they want their shower first, or breakfast first, it's up to them". A member of staff added, "I give choice to the clients, even if it's just basic stuff like choosing they want scrambled egg".

From talking with staff, it was clear that they knew people well and had a good understanding of their support needs. We were given examples by staff of how they had got to know people, their personalities and the things they liked. For example, one member of staff told us about a person who had OCD (obsessive compulsive disorder). OCD is a mental health condition where a person has obsessive thoughts and compulsive activity. They told us, "We have one client who has severe OCD, and you have to do things in a really specific way. Things have to be the same every time, from the way you enter the property, right down to the way we make cheese on toast". Most staff also knew about peoples' families and some of their interests. One staff member told us "I've taken the same client out for about two years now on an outreach call. We go bowling, play pool and have lunch. I've seen them grow in confidence and I have a really good relationship with the family. I'd put myself out for all the clients". A relative added, "The outreach worker has been able to put in place all the care my [relative] requires. As long as that continues, I'm happy with Swanborough Services".

The service had systems in place to protect people's confidentiality. People also received information around confidentiality. Care files and other confidential information about people were kept in the main office in locked filing cabinets. Information kept on the computer system was password protected. This ensured that unauthorised people could not gain access to people's private information.

Requires improvement

Is the service responsive?

Our findings

People gave us mixed feedback about being listened to and the delivery of their care being responsive to their needs. One person told us, "They listen to me and they don't tell me what to do. They have never said, you can't do anything". However another said, "No they don't respond. I care for my [relative] and have to bring in the meals before and when the carers arrive". We have identified areas of practice that needs improvement.

Each person had their individual care plan. A care plan is something that describes in an accessible way the services and support being provided to an individual. They should be put together and agreed with the person involved through the process of care planning and review. However, the majority of care plans were out of date and did not reflect the person's current wishes, aspirations or goals, or what aspect of their care delivery was important to them.

Care plans did not reflect the current types of behaviour the individual may have, such as memory loss or communication difficulties. Information was available on how the person wished to receive their care, but this was invariably out of date, with no evidence of review or continued involvement with people or their families. The interim manager told us, "Care plans should be reviewed every three months, or when people's needs have changed". This was not routinely the case, for example, one person's care plan had been developed on 2 July 2010, it had subsequently been reviewed only once on 24 September 2012. There was no information to determine if this person's needs had changed within this time, or that any regular reviews had taken place. Another person's care plan showed they had complex needs and required four care visits per day. The service had determined that the care plan should have been reviewed in March 2015 to ensure that it still met their needs, however this had not been done. A further four care plans we looked at had not been reviewed for between eleven and six months. We asked people if they could recall being involved in reviews of their care. One person told us, "Oh yes, she [office staff] came and sat beside me. It took a lot of time, but I can get access to it and ask for the book if I want to read it". However, nobody else we spoke with could give us details of being involved in a review of their care. One person said, "No, no one has asked me anything like that". Another added, "Not that I can recall".

Formal reviews of people's care ensure that any alterations in people's care and support needs can be identified and changes implemented if required. The interim manager told us they were aware the standard of people's care plans was not consistent. They said, "We've recognised that care plans were not good and out of date". The interim manager informed us that they were working hard to complete a review for each person and new paperwork in a standardised format was being introduced. A member of staff added, "The care plans are out of date. It's an ongoing process, but we are trying to catch up. It's worrying though, as how are staff supposed to know what to do?". We saw the new system of care planning. It was detailed and centred on the individual. However, at the time of our inspection only 16 care plans had been updated in this way.

We asked people if they were listened to and received personalised care that was responsive to their needs. We received mixed feedback. One person told us, "I'm listened to. If I'm getting a new girl, they always respect and listen to what I say. I've never had any trouble with that, so I am lucky". However, another person said, "No [it is not responsive]. I've been left, they don't know what I've had, or what I want". The interim manager told us they were committed to making improvements to enable the service to be responsive to people's needs.

Staff were not always deployed effectively and sufficient time was not consistently allowed for travel between visits. This resulted in staff often being late for visits. We looked at the rota for 14 – 20 September 2015. We saw that travel time had not been routinely included between scheduled care visits. Travel time should be reflective of distance and times of the day where delays could be encountered, such as during the rush hour and the school run. We spoke with the office staff about this who told us, "Some calls are running late as there is no travel time. It's agreed with the person by reducing the service contact time. We would have to change clients call times to accommodate travel time on every call". The interim manager told us, "We know the rota is an issue. It's better now than what it was, but it doesn't reflect what the care workers are actually doing during the day".

We asked staff what the thought of the call scheduling and the amount of travel time they received between each call. One member of staff told us, "I find it difficult to get to all of the calls. Travel time is either not included, or is really

Requires improvement

Is the service responsive?

limited. It's so difficult for people who don't drive". Another member of staff said, "They don't even consider travel time when they are setting up the rotas, you just have to turn up when you can. We'll have one call that ends at 7:30am and the next one is scheduled to start at 7:30am and there is no time built in to travel in between. They also don't factor in the traffic or rush hour". A further member of staff added, "Getting the call rota right is so important for people to make sure their needs are met. A morning call should be a morning call, you can't have four calls all scheduled in for 9:00am. How can I be scheduled to be in Worthing at 9:00am and then in Lewes at 9:00am as well? I've raised it with management and they just tell me I've got no choice".

Although some people told us care workers did arrive on time and they were informed if they were going to be late, people also told us staff arrived late. One person said, "Today I called them at 10:30am and said can you call me if you're going to be late, why have I been left to call you?" The interim manager told us, "If care staff are going to be late by more than 10 minutes, we get them to phone the office and we phone the client". We spoke with staff about the lateness of care calls, one member of staff told us, "There's too many calls to cover and the way the rotas are set up, we're late on numerous occasions, it just can't be done, you can't get to all the calls on time". Another said, "The rotas are a mess, there's only a few specific runs, the rest of the time you're hopping from town to town. I'm forever apologising to people for being late".

Where people relied on assistance from care workers, for example to prepare a meal or take their medicines, the current system of scheduling care calls placed them at risk of not always get the assistance they needed when they needed it. This increased the risks of people not having their nutritional needs met or becoming ill due to not having their medicine.

People did not receive the care and treatment required to meet their assessed needs, or which reflected their preferences or wishes. The scheduling of care calls placed people at risk of receiving late calls, or having their calls missed altogether. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We looked at how people's concerns and complaints were responded to, and asked people what they would do if they were unhappy with the service. One person told us, "Yes I would [make a complaint]. I'd tell the office staff there was something to discuss and they would pop in". Another person said, "We can always raise concerns with the staff. They would listen to complaints. They'd listen and take notice". Staff told us they would encourage people to raise any issues they may have. One said, "I'd always help somebody to make a complaint, even if it was about me". Records showed comments, compliments and complaints were monitored and acted upon. Complaints had been handled and responded to appropriately and any changes and learning recorded. For example, we saw that in light of one complaint, care workers were reminded that all tasks needed to be completed.

Requires improvement

Is the service well-led?

Our findings

People were unable to indicate to us whether they felt the service was well led. We found areas of practice which required improvement.

At the time of the inspection there were no formal systems of quality assurance being undertaken by the provider to measure and monitor the standard of the service provided. Some informal checks of quality were taking place, for example, the interim manager checked all medication administration records (MAR) for errors, and accidents and incidents and complaints were routinely recorded and investigated appropriately. However, we found that despite these checks and monitoring taking place, we could not identify how the provider monitored or analysed information over time to determine any trends or concerns, to create learning and to make changes or improvements to the service where required. We raised this with the interim manager, who told us, "There are no audits of quality going ahead at the moment, it was not a priority. We've recognised that the care plans were not good and we have started working on new ones, but we needed to stabilise the service after the previous manager left and concentrate on the care". There was also no formal system in place for people to be able to make comments and give feedback on the care they received in order to improve the quality of the service, such as through questionnaires and surveys.

Quality assurance is about improving service standards and ensuring that services are delivered consistently and according to legislation. The information gathered from regular audits and monitoring over time is used to recognise any shortfalls and make plans accordingly to drive up the quality of the care delivered. We have identified this as an area of practice that requires improvement.

People were placed at risk as the provider did not have effective systems to monitor and improve the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed the culture and ethos of the service with the interim manager. They told us, "We want to provide a good service and meet the needs of people. We want to value staff and support them to have a career". We asked staff about the culture within the organisation. Feedback from staff showed that they did not have a strong understanding of the vision of the service and feedback indicated that there was a lack of cohesion and a negative culture. One staff member told us, "The service is just pottering along at the moment, but it would be better to close it and start again". Another member of staff said, "It's just got worse and worse. They took on too much work and they couldn't cover it, now everything is a panic". A further member of staff added, "At the moment it's the most unstable it's ever been here. I'm not happy in my job".

We received further negative comments from staff around the day to day conduct and interactions between staff. One member of staff said, "Everything is individual. We're so busy that it's each to their own with the staff. Nobody is communicating and nobody helps each other out. There's no teamwork. There is a big divide between us and the management". Another told us, "I'm not happy here. The staff don't get along". A further member of staff told us, "We do the best with what we've got and try to keep the staff morale up".

The culture of a service directly affects the quality of life of people. A positive culture has the ethos of care built around the resident, and acknowledges the importance of fostering positive relationships between people, relatives and staff as the foundation to quality of life. Staff working as an effective team, with mutual appreciation and some blurring of roles, improves team performance and will impact positively on the quality of life for people and the wellbeing of staff.

We raised these concerns with the interim manager, who told us, "We have inherited a failing service. We are currently in the process of changing the culture from what it was. We want a lot more openness and have made changes to improve things". We saw through staff meeting minutes that managers were aware of the issues, and had asked for staff to be aware of relationships in the team and maintain professionalism.

At the time of the inspection there was no registered manager in post. The registered manager had left the service in April 2015. An interim manager and deputy manager were in charge the day to day running of the service. Staff did tell us they felt well supported by the interim manager and described her 'open door' management approach. One member of staff told us, "The [interim] manager listens to us. She is caring and understands our problems. She raises our concerns with

Requires improvement

Is the service well-led?

the provider, but that feels like it's just in one ear and out the other". Another said, "I feel like the [interim] manager has been brilliant and really supportive through all this". A further member of staff added, "The [interim] manager is very supportive and tries her best to help us".

Policy and procedural documentation was not specific to the service and related to a residential service operated by the provider. Whilst some policies and procedures were transferable to Swanborough Services, such as the whistle blowing and complaints policy, many were not relevant to a community based service. For example, the infection control policy guided staff on which coloured aprons to wear when providing care in the dining room of the residential unit. These policies and procedures would not assist or guide members of staff working within people's own homes. We have identified this as an area of practice that needs improvement.

Staff knew about whistleblowing and said they would have no hesitation in reporting any concerns they had. They reported that manager's would support them to do this in line with the provider's policy. We were told that whistle blowers were protected and viewed in a positive rather than negative light, and staff were willing to disclose concerns about poor practice. The consequence of promoting a culture of openness and honesty provides better protection for people using health and social care services.

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
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person had not ensured that they had assessed the risks to people's health and safety during any care and treatment.** **Regulation 12 (1) (2) (a) (b) (d)**

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person did not deploy sufficient numbers of staff.** **Regulation 18 (1)**

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered person had not taken proper steps to ensure people received care to meet their individual needs and to ensure their welfare and safety.** **Regulation 9 (1) (3) (a) (b)**

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person did not use systems to monitor the quality of the service effectively.** **Regulation 17 (1) (2) (a) (b) (e) (f)**