Swarthmore Housing Society Limited

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Inspection report

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Tel: 01753885663

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This unannounced inspection took place on the 5 and 6 December 2016. The home was last inspected in August 2013 where it was found to be compliant with the regulations at that time.

This residential home is registered to accommodate up to 40 older people. At the time of the inspection there were 31 people living in the home. There was a registered manager in place.
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.

Just prior to this inspection the home had an outbreak of diarrhoea and vomiting. This affected both the people living in the home and staff members. The infection was dealt with quickly and effectively but had an impact on the number of regular staff working in the home. Agency staff were used to cover for staff absences. The home had infection control policies available and these were effective throughout the outbreak. Staff had received training in infection control and how to prevent cross contamination.

Where people required assistance with medicines, these were administered by trained staff. The home had a medicine policy and this was adhered to. Medicines were stored securely, and only appropriately trained staff had access to them. We found some gaps in the guidance information for staff for "As required" medicines.

People's safety and well-being had been considered by the service and steps had been taken to ensure that any risk of harm had been assessed. Environmental risk assessments were in place alongside risk assessments related to the care provided for people.

Staff knew how to report concerns of abuse. They had received training in how to safeguard people. Staff knew how to whistle blow and had no reservations about doing so if they had concerns. Learning had taken place from safeguarding concerns, complaints, accidents and incidents to improve the service to people. We saw actions had been taken following a safeguarding concern and staff were fully engaged with the learning from this incident.

Recruitment systems were in place to ensure people were protected as far as possible from unsuitable staff.

There were mixed responses regarding the food on offer in the home. People were involved in the planning of the menus and were satisfied they were provided with an additional option if they did not like the food on offer on any particular day.

We observed poor practice with regards to people's choice, dignity and comfort during meal times. We observed one person was not given any choice about how their food was presented to them, for example

the food was mixed together on the plate. People were not always seated in a good position to eat their food safely and comfortably. We have made a recommendation to the provider about person centred care. However, most people appeared to enjoy their food and drinks were readily available throughout the day.

Staff received support through training, induction and supervision. Staff told us they felt supported in their role and from our observations we could see the registered manager had a good rapport with staff and people. Staff felt the registered manager was approachable and staff were confident to raise concerns or issues.

Staff were knowledgeable about the Mental Capacity Act 2005 (MCA) and the deprivation of liberty Safeguards. (DoLS). They understood how this applied to their work and the lives of the people they cared for. The home was working within the principles of the Act.

People told us and we observed staff were caring and kind. Their interactions were positive with people, they showed patience and spoke respectfully to people.

Activities were available to people. Some people enjoyed the activities whilst others preferred to spend time on their own. Where people could not join in activities they were visited in their rooms by staff. This protected people from the risk of social isolation.

Care records were comprehensive. Care and support was planned and delivered in a way that ensured people's safety and welfare. Risk assessments were completed in all the files we looked at. This ensured people received appropriate care.

The provider had in place a complaints procedure, which enabled people to raise complaints or concerns. Staff knew how to respond to complaints. People were able to raise complaints through the residents meetings or directly to staff or the registered manager.

We observed a team of staff who worked well together and supported each other. The registered manager was accessible and staff were confident in their abilities to manage the service.

An improvement plan was in place in the home. The registered manager and staff had engaged well with professionals who had come into the home to suggest how they could improve the quality of the care and ensure people's safety and wellbeing.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Where people required assistance with medicines these were administered by trained staff. The home has a medicine policy which was being adhered to.

People's safety and well-being had been considered by the service and steps had been taken to ensure that any risk of harm had been assessed.

People told us they felt safe and the provider had systems in place to make sure people were protected from abuse and avoidable harm.

Is the service effective?

Requires Improvement

The service was not always effective.

We observed one member of staff not offering a person choice in how their food was presented to them. People's seated positioning was not always considered by staff.

Staff had received training to carry out their roles, the training was on-going and relevant to the care being provided in the home.

Staff understood how the MCA and DoLS applied to their role and the lives of the people they were caring for.

Is the service caring?

Good

The service was caring.

Staff were described as caring and kind by people who lived in the home.

We observed how staff cared for people and found it to be appropriate, respectful and courteous.

People had input into the running of the home during residents meetings. Some people felt they had been listened to and action

taken to improve the care on offer.

Is the service responsive?

Good

The service was responsive.

A range of activities was available for people to participate in. This protected people from social isolation.

Care and support was planned and delivered in a way that ensured people's safety and welfare.

The provider had in place a complaints procedure. This enabled people to raise complaints or concerns. The complaints procedure was accessible to people.

Is the service well-led?

Good

The service was well led

Staff told us the registered manager was accessible and they felt comfortable raising issues or concerns with them.

A number of audits took place at the home. These were used to assess the quality and the safety of the service provided.

The staff worked well together as a team. Senior staff were effective in supporting care staff. The registered manager was aware of the day to day culture in the home.

Swarthmore Housing Society Limited

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 5 and 6 December 2016. The inspection team consisted of an Inspector, a specialist nurse advisor 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.

Prior to and after the inspection, we reviewed previous inspection reports and other information we held about the home including notifications. Notifications are changes or events that occur at the service which the provider has a legal duty to inform us about.

Before the inspection, we asked the provider to complete 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 reviewed the completed PIR and used this to inform our inspection.

We spoke with nine people, two volunteers, and six staff including the registered manager, the activities coordinator, a team leader and care staff. We also spoke with a local authority professional and two health professionals. Following the inspection we received information from two community health professionals who had been involved with the home. We received a copy of a compliment sent to the home after the inspection and a letter from a person prior to the inspection. We examined care records for 11 people including documents related to the management of people's medicines. We read recruitment documents relating to the employment of three staff. We observed how care was provided to people, how they reacted and interacted with staff and their environment. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk

with us.

Good

Is the service safe?

Our findings

People told us they felt safe living at Swarthmore. Comments included "You always feel safe here. It's manned 24 hours a day and there are always night staff on. The night staff are very good. One night I got stuck with my head under the bedside lamp and they had spotted it and were unravelling me before I could even call them. They come round every hour and a half to two hours and come into the room to make sure you are OK." "They seem to know exactly where I am at any time, but it (the observation) is not obtrusive."

Where people required assistance with medicines these were administered by trained staff. The home has a medicine policy and this was being adhered to. Medicines were stored securely, and only appropriately trained staff had access to them. One staff member told us and our observation verified "All medication is stored in in a lockable medication trolley or cupboard kept in a lockable room." Staff were aware of good practice guidelines and were able to verbalise it to us. One staff member said: 'We take medication very seriously, it is a big responsibility and I am very careful'. The Medication Administration Record (MAR) charts were properly maintained and appeared complete with no gaps in the recordings.

We found some gaps in the guidance information for staff for "As required" medicines. Although a medicines profile was in place some information was not clear. For example, the route of the medicines, the frequency of the medicine and the symptoms of the person and desired outcome of taking the medicine. Information of how the needs of the person may be identified for example if signs of pain were expressed in a non-verbal way. This was particularly important if people were not able to communicate with staff their need for pain relief. Prior to the inspection the home had been involved in a pilot scheme. Care Homes Integrated Services (CHIS) was a pilot scheme funded by the Clinical Commissioning Group to assess and improve health care and social care standards in residential care homes in Buckinghamshire. One of the professionals involved was a Care Homes Pharmacist. They along with a consultant Geriatrician had been into the home to review the medicines prescribed to people and the recording of medicines by staff. We spoke with the care homes pharmacist following the inspection. They told us staff were very knowledgeable about the "as required" medicines in the home and the needs of individual people. They gave an example of when they recently visited the home with a Consultant Geriatrician. Staff were able to identify a person's needs for pain relief and requested a review of their "as required" medicines. The pharmacists assured us the "as required" medicines protocols were part of the medicines review taking place in the home and were being developed to address the issue we found.
The care home pharmacist told us of some good practice they observed in the home. "I was in the home one day and all phones staff carried started to 'bleep', which initially I thought was strange, staff then said 'Madopar!' and this alarm made sure that the resident who needed Madopar (Parkinson's medication) outside of the time of the medication round had it given on time, exactly as recommended by the Parkinson's Nurse." This demonstrated that people received their medicines at the time they needed them.

At the time of our inspection a recent outbreak of vomiting and diarrhoea had occurred. This meant the staffing levels in the home had been compromised. Agency staff had been used to cover the staff vacancies caused by staff being unwell and those staff who had to be protected from the infection, for example,

because they were pregnant. During the inspection there appeared to be sufficient staff to meet people's needs. People's views about the staffing levels were mixed. Comments included "I feel safe because there are always people around." However, the same person told us in the evening they could wait up to 20 minutes for support from staff. We spoke to the registered manager about this, they were aware of the concern and were in the process of following this up. An electronic monitoring system was in place to monitor the time taken for staff to respond to calls. As a result of this concern the manager was reviewing the records to verify how long it had taken for staff to respond to the person.

Other people's comments included "The staff are harassed by their workload". Another agreed that the staff were sometimes "a bit stretched." One person told us "They (staff) like to use the hoist but I can't bear it. Sometimes I feel I must use my legs but the staff are responsible for my safety here. I like to walk using my frame with someone pushing a wheelchair behind me in case I need it, but I don't get quite enough of that. It's a question of being fully staffed."

The registered manager told us these negative comments were a result of sickness and diarrhoea outbreak. They said the situation had been difficult to manage during the infection outbreak and acknowledged the pressure that staff were put under to assist people. Another person told us when they pressed their call bell "They (staff) came, not immediately, but pretty quickly." A volunteer visitor said: "The staffing levels seem good. There is always someone floating around and the phone is answered quickly." We discussed the staffing levels in more detail with the registered manager. They told us staffing levels were decided based on the needs of the individual. At the time of the inspection there were 2 full time vacancies and two part time vacancies. These were being covered by agency staff or bank staff, all four posts had been recruited to.

Prior to people moving into the home their needs were assessed. At this point the registered manager decided on how many staffing hours the person required to meet their needs. After a month the person's needs were reassessed to ensure people were receiving the correct level of support to meet their needs. The home had in place a risk assessment regarding staffing levels, and what action needed to be taken if the staffing level was reduced. This assisted staff to know at what point external support was needed to maintain the service or in an emergency situation what action needed to be taken if the home could no longer function safely due to staffing levels. The home also had in place a business continuity plan to ensure the home could still operate in the event of utilities failure, for example flooding or electrical failure. This ensured people's safety and the risk of inappropriate care was minimised.

The home had infection control policies available. Staff had received training in infection control and how to prevent cross contamination. The home had an infection control lead which was the registered manager. The laundry staff and cleaning staff used safe infection control techniques and disposed of infected material effectively. Records were kept and other professionals informed of the recent outbreak

People's safety and well-being had been considered by the service and steps had been taken to ensure that any risk of harm had been assessed. Environmental risk assessments were in place alongside risk assessments related to the care provided for people. Health and safety checks were taking place regularly for example gas and electricity services were taking place annually. Fire safety checks including fire alarms and equipment were serviced regularly and fire drills were taking place six monthly.

Staff knew how to report concerns of abuse. They had received training in how to safeguard people. They demonstrated a good understanding of safeguarding concerns, the types of abuse possible and how to deal with them appropriately. A recent safeguarding concern had been reviewed by the home, with support from the Quality in Care Team (QiCT). This service was provided by the local authority which offers training, support and advice to care services in Buckinghamshire. Documents showed how the registered manager

and the staff had engaged with the QiCT to make improvements to the service, to ensure the safety and wellbeing of people living in the home. This was an ongoing process. The home also had a whistleblowing policy. Staff were aware of how to use this to alert the provider to any concerns. One staff member told us "I know my residents, and I would have no problem whistleblowing if I saw something wrong. Their care comes first''. This minimised the risk to people and protected them from harm.

Recruitment systems were in place to ensure people were protected as far as possible from unsuitable staff. Checks included Disclosure and Barring Service (DBS) checks, written references, health declarations, and proof of identity and of address. Where agency staff were used a profile for each staff member was sent by the agency. This confirmed their training, experience and DBS checks had been undertaken for each staff member. This process reduced the risk of unsuitable staff being employed by the home.

Requires Improvement

Is the service effective?

Our findings

There were mixed responses from people about the food on offer. People's comments included "Lots of the food is very good, though there is the occasional drop in standards," Another person, who admitted that they were "a fussy eater" said: "I dislike the food very much. There are lots of things I don't like and the carers know. They offer to make other things for me: they are very good about that." One person was involved in the catering arrangements for the home. They told us "I am rewriting the menu, which was last changed 3 months ago. I discuss it with the manager and the catering company. I am not afraid to make comments and the manager allows me to talk to the chef and invites me to meetings with the catering company." They explained in their view "The food is good, but I'd like it to be better than good. It could be better."

We carried out two observations in the dining area on the first day of the inspection and a further observation on the second day. We saw both good and poor practice. For example, one staff member encouraged people to eat and drink. They spoke to people and ensured they were enjoying their meal. Where one person asked for an alternative meal of their choice this was offered and the person was seen to eat it.

However, one person could have eaten their meal with minimal support if their seated positioning had been correct. We observed they were slumped to one side and leaning on their right arm and hand. A staff member approached them and placed an apron on them without asking the person if this was what they wanted. The person was offered a choice of drinks and a choice of vegetables with their main course. A member of staff chopped up some of the person's vegetables, again without explaining what they were doing or asking the person if this is what they wanted. The staff member proceeded to mix some of the vegetables with the main dish, without any discussion with the person. The person was handed a fork and attempted to eat their dinner with their left hand. We saw the same member of staff remove the plate after asking the person if they had finished. They had eaten approximately two thirds of their main meal. The staff brought them a bowl of custard and cake. The staff member proceeded to mix the custard and cake together stating "Just mixing these together to stop it being dry," but failed to ask the person if this was their preference. The person was still in a slouched position and in their attempt to eat their dessert was pushing the bowl to the edge of the table. Half an hour after the person was given their meal a member of staff came into the room. They noticed the positioning of the person was not conducive to them eating their meal comfortably or safely. They helped the person to reposition themselves so they were sat upright and could finish their meal using their right hand which appeared to be their preference. On the second day of the inspection we observed the same person was again not positioned properly in their chair. The same member of staff from the previous day entered the room and helped the person to reposition themselves. This meant staff were not taking into consideration people's safety and comfort during meal times.

Without the correct positioning, people were unable to eat properly and this may affect their digestion. Apart from the poor posture of people, it was not clear that people's comfort had been considered. We discussed this with the registered manager. They identified the staff member who corrected the positioning of the person. This staff member was a trained physiotherapist. On the second day of the inspection the registered manager told us the staff member was going to provide training to all staff in moving and

handling and the correct positioning of people. This would improve people's comfort and maintain their dignity and reduce the risk of harm or injury.

From our observations we could see people's food was well prepared and portion sizes were adequate. Most people appeared to enjoy their meal. The menu was on the wall for all to see, however we discussed with the registered manager how they could make the choices easier for people with dementia, for example by visually showing them the choices available each day.

From our observation of the care provided to people in relation to their positioning and for one person regarding their meal time experiences we found care was not person centred in these respects.

We recommend the registered manager seeks advice from a reputable source on how to ensure person centred care is provided to people.

People had confidence in the skills of the staff and trusted them. One person told us "They are very particular about getting your medication to you at the right time. I was snuggled up in bed and they knocked on the door to give me my night-time medication." We spoke with a professional from the QiCT. They told us how staff from the home had engaged with them and were positive about training. They said "One of the great things about Swarthmore is we have the full support of the staff." They praised the registered manager who they told us "Always wants the place to be the best it can. I have never witnessed anything but good practice."

Staff received induction training, specialised training and supervision. The induction training took the form of the four day care certificate training which included areas such as understanding the role, privacy and dignity and medicines amongst other topics. The care certificate is an identified set of 15 standards introduced in April 2015 that health and social care workers should use in their daily working life. Following this, staff had to complete practical pieces of work and their competency was assessed by the senior staff. For example carrying out basic life support. There was also an internal induction process where staff were introduced to the policies and procedures within the home. We looked at the training records for staff and found staff training in areas such as safeguarding, health and safety and infection control was all up to date. On-going training was being provided by the QiCT and this included areas such as supervision training and conflict resolution

We examined the supervision policy and the staff records. On the wall in the registered managers office was a supervision matrix, which showed all the staff names and the dates their supervision took place. We cross referenced this with the information held in each staff members supervision file. We found the information on the matrix was not up to date or accurate. Not all staff names or dates of supervision were included on the matrix. We found in the staff supervision files that supervision records did not match with the frequency expected in the provider's policy. The policy stated staff should receive supervision every 2 months or more frequently if needed. We found one staff member had not received supervision for 9 months and another for 7 months. We could see in the supervision notes where staff performance did not match with the expectation of the provider, extra supervision and support had been offered to staff. The local authority professional we spoke with from the QiCT told us they were training all staff to understand their role in supervision. This included supervision from the senior staff member's point of view as they were providing supervision to care staff. We saw records of staff appraisals, and where these were due, staff names were highlighted. The improvement to the supervision of staff was an on-going piece of work, and from speaking to the local authority, professional work was underway to improve both the quality and the value of supervision within the home.

Staff told us they felt supported in their roles. The registered manager was seen around the home and had a good rapport with people and staff. They had a hands-on approach and knew people individually. Staff were positive about the registered manager's style. They said the registered manager was 'approachable'. Staff reported they would feel able to whistle-blow or make suggestions/complaints if necessary.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. One person had an authorised DoLS in place. We checked that the conditions imposed on the provider were being met and they were. This meant that the restrictions the provider placed on the person, were the least restrictive and in the person's best interest.

Staff showed a clear understanding of how the MCA and DoLS applied to their work and the lives of the people they cared for. For example, they explained to us how the Act was applied when people did not wish to take their medicines. One staff member told us "Some residents might sometimes lack the capacity to understand the consequences of refusing to take medicines. In these situations, it may be necessary for us to act in the best interests of the person. But we always have to explain, follow procedure, fill out a form and get the pharmacist and GP involved." As staff understood the application of the Act, this meant people were protected from unlawful restraint and any action taken was in the person's best interest.

Records showed people had access to health professionals when they needed them. There was evidence in the care plans regarding their visits, the outcomes and advice from their interventions. For example, GP visits. This ensured as far as possible that people received appropriate care to help maintain their health and wellbeing.

Good

Is the service caring?

Our findings

People told us the staff were caring. One person said "The staff are very good. They ask how you feel and if there is anything they can do for you." Other comments included, "The staff are very caring. There has been illness here recently and it must have been awfully difficult to cope, but they looked after me well. They are busy, but they show me kindness and we have a few jokes," "The staff are the main thing about this place," "I was a bit miserable recently and they cheered me up." One person told us the staff were "Conscientious about bureaucracy" but lacked compassion at times, because they were overworked. We did not see any evidence of this throughout our visit.

We observed positive interactions between people and staff. One member of staff escorted a person to their room. Progress was very slow, but the staff member was patient at all times. We observed one person becoming distressed. A member of staff approached them and sat with them. The staff member spoke quietly to them in a reassuring tone and stroked their arm until they had calmed down. We saw that people's privacy, dignity and independence were respected. Consideration had been given to people's appearance, they had been supported to look smart and to dress in co-ordinating clothes. One staff member said 'I always ask what they want to wear'. Staff took time to sit beside people and chatted with them when they had time.

Residents meetings took place. We looked at the minutes of these meetings and saw that people were offered extra services over and above what was provided in the home, for example the opportunity to purchase private physiotherapy services. Discussions in the last meeting dated 27 October 2016 included informing people of a staff member attending training in "Later life" which was chair based exercises. People were also informed that a Zumba dance class was being introduced and there was a request from staff for people to feedback on how successful this was.

People were also given the opportunity to join the catering committee. This gave them a voice about what food they would like to be included on the menu and which they didn't. This meeting gave people the opportunity to be involved in the running of the home. Their comments included "If you ask a question at the residents' meeting, they will do something about it. They are very good at listening to my concerns. You can sense that they are trying to be helpful." "Our voices are listened to. For example, people with poor eyesight like me can have problems seeing food on white plates, so they are ordering some different-coloured crockery. Also, food is not always as hot as it could be if you have it in your room so they have ordered a heated food trolley."

Some people did not feel they were listened to, for example one person told "I would like there to be somewhere outside where I could walk. The path is uneven and to push the walker around is almost impossible. I have mentioned it, but money is always the issue." We discussed this with the registered manager, who informed us they had listened to the person and the work had been sent out to a contractor and they were awaiting a quote for the work to be done.

Good

Is the service responsive?

Our findings

People told us there were a range of activities they could participate in if they chose to. One person told us "There are all sorts of activities. There is plenty to do if you can." Another said "I join in activities when I can and I might enjoy them, but I never played bingo so why should I want to play it now?"

The home had two activities' co-ordinators, one working four days and the other two days per week. There were activities most mornings and afternoons including twice-weekly exercise classes, reminiscence, games, music, poetry, talks and flower arranging. A hairdresser visited twice a week. One of the co-ordinators was also a manicurist and also ran 'sensory sessions' in the quiet room with special lighting, foot massage and aromatherapy. The lead activities' co-ordinator said: "I am very lucky. I have a healthy budget." She endeavoured to bring in outside speakers and on the day of our inspection, there was a visit from a local girls' school choir, which was moderately well-attended. The activities' co-ordinator told us "I do a residents' chase to make sure everybody who wants to attend an activity is reminded about it." There are occasional trips to restaurants and to go shopping.

Once a week, volunteers take a small group of people out for a drive. The activities' co-ordinator made an effort to get to know people and discover what they would like to do. A gentleman's club had been set up. People who rarely left their rooms were visited. Some people liked to be involved in small tasks around the home and this had been arranged where possible. The activities' co-ordinator said "It is about participating in the everyday life of Swarthmore. My aim is help residents have a full life and be part of the community we are in."

Care records were comprehensive. Care and support was planned and delivered in a way that ensured people's safety and welfare. Risk assessments were completed in all the files we looked at. These included moving and handling, the likelihood of developing pressure injury and nutritional screening. Actions were in place to try and decrease risks, such as provision of pressure relieving equipment. Staff we spoke with confirmed that two staff always carried out any moving and handling that required the use of a hoist. Each person had their own personal sling. Staff demonstrated skilled moving and handling techniques when transferring people. This guaranteed people were assisted safely. When using the hoists, staff communicated with people clearly about what they were doing. We observed they worked in two's as required. Staff confirmed they were trained and updated yearly with lifting and manual handling training, commenting: "We always transfer in two's and we get training to do this. We must try and keep dignity in moving''. Care files were electronic, we found some information was repetitive. Information was not always obvious. For example when care plans changed or when they had been reviewed it was not easy to find the most up to date information. We found that care plans had been regularly reviewed and updated.

Some people had pressure sores, staff told us, "We take pressure sores seriously. Sometimes they (people) come to the home with them, but we work hard to heal them or stop them getting worse''. There was a regular repositioning routine and body maps in people's care records. Staff on duty acknowledged that dating of body maps and any corresponding photographs were important. There appeared to be a culture of diligent skin care. Staff confirmed "We frequently monitor skin during personal hygiene time, and we look

for any problems. Then we would work to lessen progress of complications and aim for recovery of good skin integrity."

Health professionals were involved in the care of people. We spoke with a visiting health professional they told us "This home is safe and always follows my instructions. They always update me, and I think the care is good" Another health professional made us aware that there were three GP surgeries supporting people in the home. Some services may struggle to manage this but they were impressed at how well Swarthmore had coped. They told us "Swarthmore has shown that it is possible to have really good medication handling even with this (three different GP surgeries involvement) challenge."

Records showed people with diabetes had care plans in place to assist staff to support people's health needs. The registered manager told us they had hypo boxes in place and sugary drinks. These were used to raise people's blood sugar levels when they dropped, this prevented people from going into a diabetic coma. Work on the care plans was taking place with the advice of a dietician, nurse and pharmacist. This was work in progress. The aim was to ensure the staff in the home had the necessary skills to be able to identify the health needs of people with diabetes. Training had been provided to staff by external professionals including a diabetic specialist nurse, a care homes pharmacist and a medical representative for blood glucose monitoring so that staff could support people living with diabetes who were at risk of hypoglycaemia or low blood glucose. This was followed by competency checks. This ensured people received appropriate and safe care and the requirement for hospital admissions would be reduced.

The provider had in place a complaints procedure, which enabled people to raise complaints or concerns, this was accessible to people. Staff knew how to respond to complaints. People were able to raise complaints through the residents meetings or directly to staff or the registered manager. Records showed the registered manager had dealt with eight complaints in the previous year. These were dealt with satisfactorily and in line with their policy. We saw where appropriate, action had been taken to resolve issues. This showed people's opinions and concerns were listened to and acted upon.

Good

Is the service well-led?

Our findings

One person told us "[the registered manager] has done a wonderful job. She's made the place. Her approach is 'it's your home and it has to be treated as your home.' She is very professional and it rubs off on her staff. She's got a good team around her, the manager, the assistant manager, the entertainments manager and the team leader." Another person wrote to us and told us the "[registered manager] is super and we all like her a lot…I do hope you appreciate my comments but it is wonderful to be happy where one lives."

We found the staff worked well together as a team. They were courteous, quiet mannered and friendly. People enjoyed talking to the staff. All staff appeared to be happy in their work, including the domestic who was cheerful and busy. Staff us the told registered manager was accessible and they felt comfortable raising issues or concerns with them. One agency member of staff told us "It is a very nice team and I like working here."

There was a management structure within the home, which had clear lines of accountability. Staff knew who to approach for guidance or support. The staff in charge assumed their roles with ease and confidence. They worked methodically and prioritised as required. They coordinated and offered support to other staff. Staff handovers took place between staff leaving a shift and those arriving. This kept staff up to date with the current needs of people.

The result of the home being involved in the CHIS project had been very beneficial to the staff and people living in the home. The registered manager told us they had found the involvement and advice offered by the visiting professionals invaluable. The information shared with the home included advice on medicine administration, health needs of individuals including skin care and diabetes care and diet and nutrition. Whilst improving standards one aim was to reduce the level of hospital admissions from services that did not provide nursing care. The registered manager spoke enthusiastically about the improvements the home had made and were still in the process of making. For example, they had introduced the roles of diabetic champions, which were staff who would be given specific information and guidance on how to care for people with this condition. This information would be shared with other staff to equip them to be able to make decisions about the care for people with diabetes. This would help prevent the deterioration of people's health as staff would be equipped and knowledgeable about what interventions if any were needed.

Alongside this, the QICT had been supporting staff with improvements in record keeping, including falls prevention. The focus of the record keeping had been to ensure accurate records were kept, which were factual and correct. Another area of training planned for the near future was in dementia awareness. This would be particularly useful to the home as a few people had memory problems and/or a diagnosis of dementia. We spoke with the registered manager about how the home could improve on its care to people who were living with dementia. For example signposting around the home and offering people choices in meals by physically presenting the meal options to them so they could make a choice. The registered manager is hoping the quality of care provided to people with dementia will be improved following the

training. This meant the manager was taking steps to improve people's quality of life who lived with dementia.

A number of audits took place at the home. These included accident and incident records, health and safety and medicines management. These were used to assess the quality and the safety of the service provided. This meant the provider could establish which areas required improvement. Safety checks were also in place. Maintenance agreements were used to ensure regular servicing of equipment, such as the hoists. This demonstrated the manager frequently checked the overall quality of the service and could drive forward improvements when necessary.

The registered manager had in place a Home Development Plan, dated 3 June 2016. This highlighted areas of care they identified as requiring improvement. Areas such as safeguarding and nutrition amongst others were identified. With the support of external agencies we saw evidence that these improvements were being made. Specialist training and cooperation from both the registered manager and staff meant staff skills and knowledge had been improved. The registered manager was responsive to the learning needs of the staff in the home. They were open and honest about how and why they wished for the standards of care in the home to improve. A visiting health professional told us "The home have always been very open and so warm and welcoming and I look forward to visiting them." A second health professional confirmed this "I have also found the staff very welcoming and open to change." We could see from the documentation and from discussions with the staff and registered manager there was real determination to improve the quality of care for people. This meant people could be confident that the care provided would be of a consistently good standard.

Feedback was sought from people, their relatives and staff in April 2016 through a survey. Documents showed where concerns were raised, for example six out of 19 staff did not feel there were sufficient numbers of staff in place, the staffing levels had been increased. The registered manager demonstrated how they listened to people's views and valued their staff by taking appropriate action to address any deficits found in the home. For example, by increasing the staffing levels and making structural adjustments where needed in the home.