

Mrs Jennifer Grego

Swanrise

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

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

Summary of findings

Overall summary

This inspection took place on 13 and 19 November 2018 and was unannounced.

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

Swanrise accommodates six people in one adapted building and is in close proximity to two other services owned by the same provider, staff work between the three services and people living in the services all interact with each other. One the day of our inspection five people were living in Swanrise.

At the time of the inspection the registered manager had not worked at the service since September 2018. There was no manager in place and no one had been asked to act up while a new manager was being appointed. 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.

The care service supports people living with a learning disability and should be developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. Meaning, people with learning disabilities and autism using the service should be able to live as ordinary a life as any citizen. However, it was not always evident that the provider understood these principals, there was not always enough staff on duty to promote independence and choice.

On the first day of this inspection, we found that there were not sufficient staff on duty to keep people safe. When we arrived, all the people who lived in the service had 1-1 support and there was no member of staff free to facilitate the inspection. People were still getting up and having their breakfast and they were not safe to be left. This meant that we started our inspection in the office examining care files and other records until a staff member was able to speak with us.

Later in the morning the general manager arrived, meaning the staff member could get back to supporting people. On the second day of the inspection, a decision had been taken to permanently add a floating staff member to the rota, however this person was to move between the three services within the same grounds and was not effective.

People were not always protected from risk. Risks in people's environment were assessed and steps have been put in place to safeguard people from harm without restricting their independence unnecessary. Risks to individual people had been identified and action had been taken to protect people from harm. However, not all the risk assessments had been kept under review or had been updated.

People's needs were assessed and they received care in line with current legislation. However, not everyone's care records had been reviewed or updated. People's daily activities were sometimes restricted because of staff not being available to support them. Staff did not always have the knowledge and skills they needed to carry out their roles. Training and supervisions had fallen behind.

The service had not been well led; failings in place prior to the registered manager leaving had not been identified by either the provider or the previous general manager, who had also recently left. However, we acknowledge that these have now been identified and the provider was taking action to make improvements. An acting manager had not been put in place while a new manager was being recruited, which meant that those shortfalls were not being properly addressed in a timely manner.

The staff had been safely recruited. People were protected from bullying, harassment, avoidable harm and abuse by staff that were trained to recognise abusive situations and how to report any incidents they witness or suspected.

Medicines were managed in a way that ensured that people received them safely and at the right time. Staff understood their roles and responsibilities.

People were asked for their consent by staff before supporting them in line with legislation and guidance. Apart from one occasion, we saw examples of positive interaction between the staff and people supported by the service. People were able to express their views and staff listened to what they said and took action to ensure their decisions were acted on. Staff protected people's privacy and dignity.

We saw that people received care that was personalised and responsive to their needs. The service listened to people's experiences, concerns and complaints. They took steps to investigate complaints

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not always safe.

There were not always sufficient staff to support people to be safe. Risk assessments were not always reviewed or updated.

The staff were safely recruited and understood their responsibilities to raise concerns. People were protected from bullying, harassment and abuse.

Medicines were managed in a way that ensured that people received them safely and at the right time. People were protected by the prevention and control of infection.

Is the service effective?

Good ●

The service was effective.

People's needs were assessed and care records were in the process of being reviewed and updated.

Staff had the knowledge, skills and support they needed to carry out their roles and training was being updated.

People were asked for their consent by staff before supporting them in line with legislation and guidance.

Is the service caring?

Good ●

The service was caring.

There was positive interaction between the staff and people supported by the service. People were able to express their views and staff listened to what they said and took action to ensure their decisions were acted on. Staff protected people's privacy and dignity.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

Care plans were detailed and gave staff the information they needed to support people and to meet their needs, but they were not always updated. People's took part in daily activities, but were sometimes missed because there were not always enough staff on duty for them to go ahead.

The service listened to people's experiences, concerns and complaints and took steps to investigate them.

Is the service well-led?

Requires Improvement ●

The service was not always well-led.

Quality assurance systems were not robust, management shortfalls had not been identified.

Swanrise

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 checked 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 comprehensive inspection was carried out on 13 and 19 November. We bought this inspection forward because we had received concerns from relatives and members of the public who lived close to the service.

The inspection was undertaken by one inspector. We reviewed three people's care records, records relating to the management of the service, training records, and the recruitment records of three staff.

Not all the people living in the service were able to talk with us. During our inspection we observed how the staff interacted with people who used the service, including during their lunchtime meal. We spoke with two people living in the service, the general manager/area manager, two deputy managers, who also worked in that capacity in the provider's two other services that were in close proximity and four staff members.

We reviewed information we held about the service, including notifications we received from the service. Notifications are required by law which tells us about important events and incidents and the actions taken by the service. We also reviewed information sent to us from other stakeholders for example the local authority and members of the public.

We reviewed information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Is the service safe?

Our findings

At our last inspection in August 2016, the key question for safe was rated good. At this inspection we found that people did not always receive a service that was safe.

One the first day of our inspection we found that people were not protected by sufficient numbers of staff being available to keep people safe. Apart from one, who had nine hours 1-1 support staff, each person had a 1-1 staff member with them during the day because they needed to have staff with them to help them manage their behaviours that challenge and to keep them safe. However, there was no back up staff to support the 1-1 staff, if they needed a comfort break or so they could be relieved to have a meal break. The staff member who supported the person for nine hours of their 12 hour shift, was expected to prepare meals and deal with other chores at times the person was spending time on their own.

Staff were not given scheduled breaks and were expected to work without a break throughout a twelve hours shift. In an emergency situation, involving another person using the service, staff would need to leave the person they were working with to assist their colleagues. Throughout the morning on the first day of our inspection, one person was showing signs of being unhappy and displayed behaviours that challenged the staff, in turn their behaviour had other people unsettled. Staff knew how to support the person, were aware of their triggers and took steps to help them feel better. However, this had an impact on staffing because at times two staff members were needed to support that person, which meant the other people were left on their own and vulnerable at a time when their own anxieties were elevated.

Staff we spoke with all told us that there were times they did not feel safe because there were not enough staff. Neither were they confident that other staff would be able to offer them support quickly if they needed it. Staff felt that there were times during a twelve-hour shift working with the same person, they became tired and needed to have a break to help with concentration.

On the second day of our inspection, we were told that the provider had put an extra 'floating' staff member on the rota. However, they were expected to cover all three of the provider's locations that were in very close proximity to each other, meaning that they would possibly not be available to support the service that needed assistance.

When the previous registered manager left, the post was left vacant and the deputy managers were expected to take over the manager's tasks. Both the deputy managers, who carried out their roles over the three services, were expected to cover shifts and had very few office hours, meaning that several management tasks were not kept up to date. Not having the vacancy covered by an acting manager also meant that there was no one available to step in to offer support to the staff if needed in difficult situations.

There were not sufficient staff on duty to properly protect people and staff from harm. This is a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18 Staffing.

Risks to people were assessed and steps had been put in place to safeguard people from harm without

restricting their independence unnecessarily. Risks to individual people had been identified, but action put in place to protect people from harm may not always be taken because of insufficient staff being on duty to carry them out.

The people living in the home sometimes exhibited behaviours that might challenge others. We saw that there was detailed information regarding the triggers for people and ways to manage the behaviours to protect the person and others around them. However not all the risk assessments had been kept under review or had been updated.

This had been recognised after the previous registered manager had left and steps were being taken to make sure that risk assessments were reviewed. However, poor staffing levels meant that not all risks could be protected against. Some people's risk assessments said that at times of heightened anxiety the person should be supported by two staff. At the staffing levels, set during our inspection, the only staff available to help were those already working on a 1-1 basis.

People were supported by staff who had undergone required recruitment checks to ensure that they had not previously been deemed unfit to provide care and support. We saw that references from previous employers of new recruits had been sought by the manager. Disclosure and Barring Service (DBS) checks had been carried out to show the applicant's suitability for this type of work. The DBS provides information about an individual's suitability to work with people to assist employers in making safer recruitment decisions.

Staff told us and records confirmed, they had received training in protecting adults from abuse and how to raise concerns. They were able to demonstrate the action they would take and tell us who they would report concerns to in order to protect people. Staff understood the different types of abuse and knew how to recognise signs of harm and understood their responsibilities to report issues if they suspected harm or poor practice. They were confident that action would be taken if they reported any concerns. One member of staff said, "We have a list of people and phone numbers in the office who we can go to if we think something's up." Staff were also aware of the whistleblowing policy and said they would feel confident to use the process if they thought it was necessary.

People received their medicines in the way that they wanted from staff who had received training in the administration of medicines. Medicines were stored appropriately in locked cabinets and when we checked stocks of medicines they matched the amounts indicated on the medicines administration records (MAR) charts. We saw that details of people's medicines were recorded and all administrations had been signed by staff. We also saw protocols for people who had been prescribed PRN (as needed) medicines which contained information on when the person would need the medicine. We noted that each person's care plan also provided staff with guidance on how the person preferred to take their medicines.

The service was clean and hygienic. Staff were trained in infection control and food hygiene, those we spoke with understood their roles and responsibilities in relation to infection control and hygiene. There were systems in place to reduce the risks of cross infection. All the bathrooms and toilets had liquid soap and hand sanitiser and disposable paper towels for people to use. There were gloves and aprons around the service that staff could use to limit the risks of cross contamination.

Is the service effective?

Our findings

At our last inspection in August 2016, the key question for effective was rated good. At this inspection we found that people received a service that was effective.

People told us that they were supported well and that staff made sure that they got what they needed. One person told us, "They [the staff] help me when I need it and leave me alone when I want to be left alone. They are good people" Another person said, "I like it here, my room is how I want it, they [the staff] know me well and help me do what I want." Records showed that staff had been receiving training and support to enable them to do their jobs effectively. However, training and supervisions had fallen behind, this had been recognised and action had been taken to arrange training and resume staff supervisions.

Staff told us they had recently been offered update training and felt they were mainly up to date, they had also begun to have supervision again. Staff received training including health and safety, first aid and infection control. They were also offered training that was appropriate to supporting people living with a learning disability, for example working with people with autism and developing communication skills. This enabled them to develop the skills they needed to carry out their roles and responsibilities.

On speaking with staff, we found them to be knowledgeable and skilled in their role. We were told the service supported staff to gain industry recognised qualifications in care. This meant people were cared for by skilled staff, trained to meet their care needs.

People's care records showed that their day to day health needs were being met and that they had access to healthcare professionals according to their specific needs. The home had regular contact with a GP surgery that provided support and assisted staff in the delivery of people's healthcare. Records showed that people were supported to attend hospital and other healthcare professionals away from the service. For example, specialist clinics and diagnostic tests.

The service tried many ways to support one person who was having difficulties managing their mental health, meaning they displayed disruptive behaviours in and outside the service. They left the service on several occasions and their behaviour and actions caused disquiet amongst people living close to the service and caused them concern. Eventually, after receiving professional support it was recognised that the service could no longer support that person's needs. They took appropriate action to get the person moved to a service where they could get the help they needed from the mental health care services.

People told us that they enjoyed their food, people helped in planning the week's menu. Staff were knowledgeable about supporting people to eat healthily and meeting their individually assessed dietary needs. Staff were able to give us examples of people's dietary needs.

The service worked with other professionals involved in people's care to ensure that their needs were met in a consistent and effective way. People were supported to maintain good health and had access to health professionals if needed. We saw in each person's care plan that a hospital passport had been written to

provide hospital staff with information on how best to meet the person's needs while they were in hospital. Staff accompanied people on visits to hospital to reduce the risk of the person becoming distressed by the process. One person said, "They will call out the GP if I need it." Another person commented, "If I feel ill, they help me to see the doctor."

The service was adapted to give people space they where they could relax and have their own possessions around them. There were areas that people could spend time on their own in quiet areas, some had their own lounges as well as access to communal areas and a secure/safe garden. A small part of the garden had been adapted to enable one person to safely spend time in the garden.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). People using the service had their capacity to make decisions and consent to their care assessed appropriately under the MCA. DoLS applications had been made to the local authority and were authorised where appropriate.

Management of MCA and DoLS had been well managed, staff knew when these should be applied to the people who lived in the service, including how to consider their capacity to make decisions. Where people lacked capacity, the care plans showed that relevant people, such as their relatives or GP had been involved in making decisions about their care. Any decision made on behalf of a person was done in their best interest and the least restrictive option was chosen so that people could still make some decisions for themselves and keep control of their lives.

Is the service caring?

Our findings

At our last inspection in August 2016, the key question for caring was rated good. At this inspection we found that people still received a service that was good.

People felt that staff treated them well and were kind. One person said, "[The staff] are good, we get on okay and have a laugh, they know me and we get on fine."

Apart from one example, we saw interactions between people and members of staff that were caring and supportive and which demonstrated that staff listened to people. Staff clearly knew people very well and were able to tell us specific information about them. For instance, one member of staff gave us examples of how the person they were supporting liked to spend their time, including very specific detail about their preferences. However, one staff member supporting a person who had limited communication skills, failed to interact with them in a meaningful way. They spoke in one-word sentences or did not talk to the person while they supported them. The person was told to 'eat' their lunch and 'sit there'. We brought this to the attention of one of the deputy managers who assured us they would speak to the staff member and would offer them training in meeting people's communication needs.

People's care plans contained a brief description of their personal history, their personal care abilities and support needs and their social interaction skills. They were very detailed. The care plans focussed on the promotion of people's choice and independence. For instance, we noted in one person's care plan there was guidance on how to support them with their personal care. This included guidance on the best way to communicate with the person, what they were able to do for themselves, where they needed prompting and what support they needed. This helped staff become familiar with the person's likes and expectations so they could build good a relationship with them.

There was evidence in the care plans that people and their families had contributed to the assessment and planning of their care. The care plans had been regularly reviewed and staff made contact with people's families to ensure that they were involved with people's care. Family members were invited to an annual review of the plans. People had signed their care plans to show that they had taken part in writing the care plan and were happy with the content.

People were treated with dignity and respect and staff were discreet when asking people if they needed support with personal care. We observed staff knocking on people's doors and waiting to be invited in before entering. Doors were closed during personal care tasks to protect people's dignity.

Is the service responsive?

Our findings

At our last inspection in August 2016, the key question for responsive was rated good. At this inspection we found that people did not always receive a service that was responsive.

People who were able to talk with us, told us that they thought the service responded to their needs. One person said, "They [the staff] are there when I need them." And "We go out and do my shopping together." Staff supported people with activities that reflected their interests and pastimes, the focus was on what the individual wanted to do, whether that was sitting having a chat, watching their favourite soap on the television or joining in a planned social activity. However, trips out were sometimes restricted because there were not enough staff on duty support people while out of the service. Some people were assessed as needing two members of staff to go out with them for their own safety. The staffing numbers did not allow for those people to get out unless extra staff were put on duty for a planned trip. We were told that this was not routinely done and, if a staff member was ill and not at work, the trip would be cancelled so the absence could be covered. This meant that spontaneity was not catered for.

People said that they had been told what they needed to know about the service before they moved and they were asked about what they wanted to happen to them once they moved in. They also told us that their families were included during the assessment process. Staff told us that as many agencies as possible were contacted to have an input into people's assessments. Professionals such as speech and language or their social workers for example. Care plans were developed from the assessments and recorded information about the person's likes, dislikes and their care needs. Care plans were very detailed and gave enough information for the carer to understand fully how to deliver care to people in a way that they wanted to be supported. The outcomes for people included supporting and encouraging independence in areas that they were able to be, such as choosing their own clothes, what they like to eat and how they wanted to live their lives. One person said, "I have my own way of doing things." However, they had not been kept under review. That had been recognised and plans were in place to change the care plan format and to update them.

People told us about their life living in Swanrise and shared stories with us of things they had done and how they kept themselves busy. One person told us about a holiday they were about to book and how they were looking forward to it.

The garden was well maintained and we saw people taking part in activities in the garden, one person liked to help keep it tidy and another regularly fed the birds.

People proudly showed us examples of their handy work such as drawing and model work. One person showed us their room and they told us how they were able to arrange it as they preferred and that staff helped them in keeping it clean and tidy, "Not too tidy though, I like my things where I put them."

People were supported to keep in touch with people that were important to them such as family and friends, so that they could maintain relationships and avoid social isolation. One person told us, "I speak with my [family member] on the phone and go and visit them sometimes."

People told us that they had not needed to complain often, but when they did, staff helped them to make the complaint and it was always dealt with to their satisfaction. The provider had a procedure in place to manage any concerns or complaints that were raised by people or their relatives. The complaints procedure was displayed in the service and there was an easy read copy in people's care files. The general manager said that they encouraged people to raise concerns at an early stage so that they could learn from them and improve the service. They also commented that they always took steps to investigate complaints, learn by their mistakes and to make any changes needed.

People were asked about their preference in regard to their end of life care, but had not wanted to talk about this part of their life. The deputy manager said that they respected their wishes in this regard, all the people they supported were young adults in good physical health. However, if anyone was to become unwell advice and input from palliative care professionals would be promptly sought. When needed, people would be provided with appropriate support, equipment and medicines to ensure they were comfortable, dignified and pain free at the end of their lives.

Is the service well-led?

Our findings

At our last inspection in August 2016, the key question for well-led was rated good. At this inspection we found that people did not always receive a service that was well-led.

The service had not been well led; after two recent management changes, it had been identified that there had been management shortfalls. An acting manager had not been put in place while a new manager was being recruited, which meant that those shortfalls were not properly addressed in a timely manner. Consequently, care reviews, staff training, meetings and supervisions had not been taking place. Nor were meaningful quality assurance checks being carried out and the provider did not carry out provider quality assurance visits to assure themselves that the service was being properly managed and that people were receiving a good quality of service.

The general manager, who was new to the post, had been spending several days a week in the service and changes and improvement were planned, but they also had other responsibilities in their role and their plans were taking time to be implemented.

The deputy managers did not have sufficient allocated office hours to manage the service effectively in the absence of a manager, they had been rostered to work on shift so they were unable to keep up with the day to day management tasks.

The people being supported and staff told us that the management team was supportive, but they did not feel there were sufficient staff on duty and that there were improvements needed to improve the service people received.

The quality of the service offered to people had been deteriorating for several months. Failings, in place prior to the registered manager leaving in September 2018, had not been identified by either the provider or the previous general manager. This indicated that there were insufficient systems in place to monitor the quality of service the provider offered people.

There were not sufficient staff to keep people safe and to enable them take part in activities outside the service. One person had nine hours 1-1 staff support and the others needed 1-1 staffing all day. Having no extra staff on shift to enable 1-1 staff to have a meal or comfort break meant that people were not always having their assessed needs met when they were left for staff to help other staff who need support to have a break or to help out in emergency situations

The failure of the provider to replace the registered manager with an acting manager led to the service being further short staffed because the deputy managers were expected to work shifts and to manage all three of the locations the provider had in very close proximity to each other. All the staff worked between the three services.

There were not sufficient quality assurance systems in place to safeguard people and to assure people

received a good quality of service. This is a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 Good Governance.

However, we acknowledge that these shortfalls, apart from staffing levels, had been identified prior to our inspection and the provider was taking action to make improvements.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were not sufficient, robust quality assurance systems in place to safeguard people and to assure people received a good quality of service.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient staff on duty to properly protect people and staff from harm.