Swanton Care & Community Limited

Swanton House Care Centre

Inspection report

Dereham Road
Swanton Novers
Norfolk
NR24 2QT

Tel: 01263860226
Website: www.barchester.com

Date of inspection visit:
31 March 2016
05 April 2016

Date of publication:
20 May 2016

Ratings

Overall rating for this service	Requires Improvement

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?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 31 March and 5 April 2016 and was unannounced.

The service provides accommodation and support with personal care or nursing needs to a maximum of 49 people. It is divided into three different units, two of which are purpose built. Some people using the service needed support with their mental health needs. For other people their needs were age related or they were living with dementia. The provider set out on the home's website and to the Care Quality Commission (CQC) that they can also provide support to people with a learning disability or autism. At the time of our inspection there were 46 people using the service.

There was a registered manager in place. A registered manager is a person who has registered with CQC 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 current manager had completed registration with CQC in February 2016.

At our last inspection on 24 April 2014, concerns were identified that care plans did not all contain relevant information about people's needs and were not updated regularly. At this inspection we found that action had been taken so that staff had access to information about the care people required.

People experienced a service that was safe. Staffing levels had improved and people received support from staff in a timely and safe way. Staff understood their obligations to report any concerns that people may be at risk of abuse or harm. The risks to which people were exposed were assessed with guidance for staff about how to minimise these.

Medicines were managed in a safe way.

The service people received was not consistently effective. Mealtime routines did not always provide an experience conducive to encouraging people to enjoy their meals. There were shortfalls in the way that people's intake of food and drink was monitored and encouraged to ensure this was sufficient for their wellbeing and health. We have told the provider they need to make improvements in this area.

Although underpinning written assessments of people's capacity to make informed decisions were not always properly completed, staff understood their responsibilities under the Mental Capacity Act 2005 for supporting people to make decisions. Action had been taken to ensure people's rights and freedoms were protected and that any restrictions were considered to see if these were appropriate.

Staff ensured that prompt action was taken to seek advice about people's health when they became unwell.

People received support from staff who were kind and compassionate. Staff took action to intervene

promptly when people became distressed and needed reassurance. They respected people's privacy and dignity.

The service was responsive to people's needs and preferences. Staff were flexible in the way they delivered care to people. They took into account individual preferences and day-to-day changes in their wellbeing before tailoring how they offered support that people needed.

Although people were not all aware of the formal process for making complaints, they were confident that any concerns they needed to raise would be dealt with properly.

People experienced a service that had not been consistently well-led. Changes in management arrangements, both within the provider's management team and within the service, compromised the ability of the service to demonstrate consistent, stable and appropriate leadership. The new arrangements needed time to consolidate to ensure identified improvements were made and sustained, taking into account the views of people using and working in the service.

You can see what action we told the provider to take at the back of the full version of the report.

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.

Recruitment processes were robust and contributed to promoting people's safety. Staff understood the importance of protecting people from abuse. There were enough staff to attend to people's care needs safely.

Medicines were managed in a way that promoted people's safety.

Equipment was tested regularly to ensure it remained safe for people and staff to use, and emergency systems for detecting and extinguishing fires were properly serviced.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The service could not demonstrate that people living with dementia had enough to eat and drink.

People were not always supported by staff with the knowledge and skills to meet their needs effectively, although this was improving.

Staff understood how to support people who may be unable to make informed decisions about their care.

Where there were concerns about people's health and wellbeing, relevant advice was sought promptly.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and compassionate.

Staff offered reassurance and support promptly when people became distressed or anxious.

People were treated with respect for their privacy, dignity and independence.

Is the service responsive?

Good

The service was responsive.

Staff were flexible in the way they supported people and took into account how their needs might change on a daily basis.

Staff understood what was important to people they were supporting and recognised how support with social, recreational needs and hobbies contributed to people's wellbeing.

People were confident that any complaints they raised would be properly addressed.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Frequent changes in the leadership of the service had adversely affected staff morale. They had also affected the way that improvements were identified, made and sustained.

Recent changes in the staffing structure and management arrangements had not had time to embed to demonstrate consistent leadership.

Swanton House Care Centre

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.

The inspection took place on 31 March and 5 April 2016 and was unannounced.

It was completed by two inspectors 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.

Before we visited the service we reviewed the information we held about it. The information included notifications about events taking place within the care home, which the provider is required to tell us about by law. We also reviewed reports supplied to us by the local Commissioning Support Unit arising from their visits to the service.

During the inspection we spoke with six people using the service and two visitors. We also spoke with three nurses, three care staff and both unit managers. We spoke with the registered manager, regional manager, activities coordinator, housekeeper and a visiting GP. We also observed how people were being supported.

We reviewed records associated with the care of five people and medicines records for the people living in the main house. We reviewed training records and the supervision schedule for the staff team. We also reviewed a sample of records associated with the safety and quality of the service, including maintenance records, risk assessments and internal audits of systems in place.

Good

Is the service safe?

Our findings

Systems for managing and administering medicines contributed to promoting people's safety.

One visitor to the service told us that they had sometimes found medicines on the bed or chair of the person they came to see. They said they would like more attention paid to ensuring the person had actually ingested them so that they had taken the medicines they were prescribed. They acknowledged that this could have been the result of staff not wanting to intrude while they were visiting; they told us they would normally make sure the person took the medicines themselves. We raised this with the management team as being a staff responsibility.

We observed some medicines being administered to people and the staff member responsible ensuring that they were taken. This included where one person needed to have medication administered in thickened form to avoid choking. The nurse sought assistance from a staff member who was used to assisting the person with their drinks and meals. The nurse remained with the carer throughout the administration of the medication and checked it was all taken.

We found that people's medicines administration record (MAR) charts contained current photographs of each person to assist staff in administering medicines correctly. The MAR charts also contained relevant information about people's needs, how they preferred to take their medicines, allergies and details of their GP. There were sample signatures and initials of staff who were responsible for administering medicines so that it was possible to see who had been responsible.

There were audit systems in place for medicines. These had identified where signatures for administering medicines had been omitted from MAR charts, indicating staff were not following the expected process. We saw that a memorandum for nursing staff had been issued and was displayed in one unit highlighting this concern. As a result of these, additional checks had been put into place for hand-overs within each unit. Nurses confirmed they had reviewed the MAR charts to ensure they were accurately completed. All the MAR charts we reviewed and in use since the additional check was introduced, were fully and appropriately completed.

There was guidance for staff about reporting errors. Nurses spoken with were clear about the process for doing this and ensuring advice was taken about people's welfare and safety. Additional guidance was in place outlining what to do if people had refused an essential medicine twice in succession, prompting staff to seek advice from the GP about their welfare.

There was guidance in place about the administration of medicines that were prescribed for occasional use, for example to aid people who had become distressed. Reports of visits from service commissioners concluded that these sedative medicines were not being used inappropriately. We found that, where these medicines had been used, there was clear recording of the decision about why they were needed. We observed that one person was administered and accepted such a medicine during our visit. The administration of the medicine was consistent with guidance for the person about its usage.

Medicines were stored securely so that only trained staff had access to medicine supplies. There were minor gaps in the recording of storage temperatures to ensure that temperature sensitive medicines remained safe and effective to use.

There were systems in place that contributed to protecting people from the risk of abuse.

Two people using the service told us that they felt staff were nice to them and looked after them well. They had no concerns about the way they were treated or their safety. One said, "Yes, we're safe here." A regular visitor to the service told us, "There's no 'undercurrent' at all." They went on to explain that they had no concerns about the way they had heard staff speaking to anyone living in the home.

Staff spoken with were clear about their obligations to report any suspicions or concerns that people may be at risk of abuse. Staff told us, and the training schedule confirmed that the majority of staff had completed training in safeguarding people recently. There were some gaps still to be addressed but the management team was aware of this and had plans to address omissions.

We saw that details were displayed in a staff office showing how staff could contact the local safeguarding team directly if they needed to. Our discussions with the management team showed that staff had raised concerns in the past. The management team had worked with the safeguarding team with any investigation that was required and had referred concerns appropriately.

We saw that there was information displayed for staff about how to blow the whistle on poor practice. This provided information about a telephone line staff could contact if they were not able to raise concerns within the service for any reason.

Risks to people's safety associated with their care needs or from the premises were assessed and managed.

Risks to people's welfare and safety were assessed within their plans of care. Guidance was provided for staff about how they should promote people's safety. The management team was aware that these assessments were not always reviewed each month as records indicated they should be, but we found changes in risk had been incorporated.

Risks to people from falls and poor mobility were documented. Staff had access to equipment to assist people with their mobility and the majority of the staff team had completed training to do this safely. Equipment used to assist people with their mobility was serviced regularly to ensure it remained safe to use.

We noted that staff followed guidance for people who were at risk of choking. For example, one person needed to have a soft diet and their drinks thickened. We saw that this happened to minimise the risk of the person choking. People at risk of developing pressure ulcers had pressure relieving equipment in place to help ensure their skin integrity was maintained.

While we were present, risks associated with the operation of some working practices and the use of kitchen equipment were updated. We noted that the assessment of risks associated with the operation of the premises was updated on 29 March 2016.

We found that fire detection systems were tested regularly and that most staff had received training to respond to a fire. The last inspection by the fire service was in August 2015 and their report showed they were satisfied that arrangements within the service was satisfactory.

There were enough staff to meet people's needs safely.

People told us that there were enough staff to meet their needs. For example, a visitor to the service told us how, when their relative needed assistance, "They [staff] were there almost instantly." Staff told us that, although they were sometimes short staffed, improvements had been made in staffing levels. They described how this improvement was welcomed because of the level of support some people needed to deliver their personal care safely. They said that the management team did their best to cover absence occurring at short notice and would help out in an emergency if it was necessary.

We noted that fewer staff were around when staff took the breaks to which they were entitled as a result of working long shifts. However, this was organised after people had been assisted with their lunch. We observed in the main house that it did not lead to people waiting for prolonged periods before receiving assistance. Staff were very busy during this time but the longest delay we timed between a call bell sounding and being answered was three minutes.

We found that the service used regular agency staff to cover shifts. Staff attributed this to the location of the service, which was remote, leading to difficulties in recruitment. However, we learned from staff and the management team that the same agency staff were generally used so that they had got to know the way the service worked and the support that people required. The management team told us that there were six staff who had been recruited and would be starting induction at the home in April.

Recruitment practices contributed to protecting people from abuse.

A staff member told us about the checks that had been made before they were appointed to work at the home. The provider's recruitment processes ensured that prospective staff were asked for full employment histories and an explanation of gaps. References and enhanced checks on the suitability of applicants were completed to ensure prospective staff were not barred from working in care.

Requires Improvement

Is the service effective?

Our findings

The majority of people were satisfied with the arrangements for drinks and meals. However, the service could not demonstrate that some people living with dementia consistently had enough to eat and drink.

We noted that a visit by commissioners of the service took place on 4 March 2016. They had also visited previously in October and December 2015. Reports from all of these visits showed that, where people were at risk of poor nutrition or hydration, the amounts they had to eat or drink were not always recorded. The reports reflected concerns about how the service could show people were having enough to eat and drink, particularly where they were at high risk in this area.

The registered manager had identified similar concerns in one of the three units at the home and in response to the commissioners' report. We had concerns relating to two of the three units where we checked records of people's eating and drinking. We raised with the management team that action had not been robust in ensuring staff were effectively and consistently supporting people to eat and drink enough.

We reviewed the records for a person assessed as at risk of not drinking enough and whose care plan said that their intake needed to be monitored. Monitoring systems were not effective in ensuring they had taken enough fluids. For example, their records for one day showed they only drank 650ml of fluid. Three days later only 220ml was shown as their intake for the day. The person had experienced two recent urine infections and their monitoring records showed that their fluid intake had been low. There was no target amount for amount of fluids staff should encourage for this person or for others who were being monitored. This presented a risk that staff would not be aware of the need for action to encourage more drinks to promote people's welfare.

We noted that there was a water dispenser in the main unit of the home but there were no cups available for people to help themselves to drinks if they were able to do so. We observed that one person who was unable to prepare a drink for themselves, was offered one which they said they would like. However, the staff member offering it went to deal with a telephone call. It was over ten minutes before another staff member offered and provided a drink for them.

A visitor told us that they were concerned about the person they came to see having lost a large amount of weight. They told us they thought, "…with a little more care they [staff] could get [person] to eat more." We noted that there was some inconsistency in the person's care plan detailing the support they required. This presented a risk that staff would not be fully aware of the support they needed to eat well. One part of their plan indicated that they could eat and drink independently but showed elsewhere that they needed staff to prompt and encourage with eating and drinking.

The person's care records showed an urgent referral for advice from a dietician had been requested in January 2016. This followed significant weight loss of over 7kg between their weight being checked on 1 December 2015 and again on 3 January 2016. Guidance in their care plan indicated that they needed to be given high calorie snacks throughout the day. Their record of food intake and daily progress notes did not

show this happened consistently between meals or when they had refused a main meal.

The person's care plan also showed that they needed to be weighed weekly to ensure their health was being more frequently monitored. This had not happened. Their weight was recorded twice in January 2016 but only once in each of the next two months. This presented a risk that staff would not be able to identify promptly whether additional interventions were needed.

For another person, staff told us that they had recently introduced fluid and food charts because that person too had lost weight. The person was to be encouraged with fortified meals and snacks in between. We reviewed the records for the week leading up to our inspection. These did not consistently show what the person had eaten or, if they had only eaten a part of their meal, what snacks had been offered to boost their calorie intake.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that, in two units at the home, the mealtime routine was disorganised. We discussed with the management team how this may not be conducive to people eating and drinking well. The lack of organisation also compromised the ability of staff to accurately monitor people's food and fluid intake. For example, a staff member told us that one person had already eaten their lunch. However, we observed that another staff member directed them from the corridor towards the dining area when they asked about having their lunch. A staff member in the dining area said they would fetch them a yoghurt but did not return with it. Once sitting in the dining area the person kept repeating, "…lunch, lunch..." to themselves. Another staff member later spoke with them and offered and served them some food.

We saw that people in one unit were sitting at the dining table waiting for their food for approximately 15 minutes. During that time one person got up and left the table repeatedly saying they were going for a walk. In the neighbouring unit we observed that one person spilt their drink, which went unnoticed by staff until the person became very anxious and distressed. The television was tuned to children's programmes, which the provider told us was people's choice. No-one was watching it during the meal but it was noisy and potentially distracting throughout the lunch period.

This contrasted with other people's experiences who said they enjoyed their mealtimes. They told us that the food was good. One person said, "The food is lovely." Another person told us how they were really looking forward to their lunch. A regular visitor to the service said, "The food is as good as any restaurant." Another visitor commented to us, "The food is lovely. I eat here with [person]. It's always nice."

We saw that two people sharing a table at lunch had selected two different meals, according to their preference. They were also offered a choice of hot and cold drinks to go with their meal. We noted that one person, choosing to eat in the reception area, was eating a third different meal of a selection of cheeses and salad. We observed that staff who supported people with eating and drinking, sat alongside them and assisted them at their own pace.

Staff were not always properly trained to meet the specific needs of the people they were supporting but the new management team were aware of this and it was being addressed.

The provider had a list of 'core' training they expected staff to complete but we found that there were significant gaps in this. For example, we found that only just over a third of care staff had completed core training in dignity and person centred approaches. In addition, the provider had also identified training that

was specific to the service. We reviewed staff having completed this and also found deficits. Despite the service supporting people who were living with dementia, less than a third of the care staff team had completed training to enable them to support people who were living with this condition.

However, during our inspection, three staff attended a 'Virtual Dementia Tour' course and spoke enthusiastically of the experience. In addition, a member of the provider's training team was completing observations of staff to see which aspects of their knowledge and competence in supporting people who were living with dementia needed to be addressed.

Staff spoken with recognised that there had been in increase in the training provided since the current registered manager took over. One staff member described this as, "…a major overhaul of training." They said that e-learning had not been popular with some staff because it could often take longer than the time they were allocated for completion. They added that, if staff were not very used to using computers, this presented additional difficulties. We noted from our discussions with staff and the manager, that staff were able to pursue additional qualifications that were appropriate to their roles if they wished to do so.

The management team had established a schedule for ensuring staff received supervision. There remained some gaps but the unit managers and registered manager were reviewing these. Supervision is needed so that staff have the opportunity to discuss their role, performance and development needs. Two members of the management team had been transferred to the home to assist the registered manager in December 2015, initially on a temporary basis for three months. This meant that arrangements had not yet consolidated so that supervision and support could stabilise and improve. However, staff members told us that they felt well supported by more senior staff including the new management team.

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.

Staff understood the importance of supporting people to make their own decisions. However, documentation was not always clear about how people's capacity had been assessed and how decisions taken represented their best interests.

We noted that written assessments of people's capacity were not based on specific individual decisions. They did not properly reflect the abilities of each person to understand and give informed consent to specific aspects of their care. We also found that there was some confusion by staff completing care records, about the role of lasting powers of attorney (LPA).

The previous manager told us that 17 people living in the service had these LPAs in place. We asked the current management team for an update regarding this. They were surprised about the number and agreed it was unlikely that there would be so many effective LPAs in place for decisions about health and welfare for people. Information in assessments we reviewed did not clearly distinguish whether relatives had LPA for

finances or over decisions to do with people's health and welfare. For example, one person had a relative recorded as having legal powers to make decisions over both finances and health and welfare, but without evidence that the latter was legally in place. This presented a risk that the relative might consent to treatment or intervention on the person's behalf without proper authority. The management team accepted the need to review this.

About three quarters of the care staff team had completed relevant training within the last year to help them understand their responsibilities under the MCA and DoLS. Despite the lack of clarity in records, staff were able to give us clear accounts of how they sought to explain to people what care was considered necessary. They said they would try to persuade people to accept support, for example with personal care. They recognised that sometimes people's capacity to understand and accept care varied because of their mental health or dementia. They understood the importance of being flexible and trying again later or involving a different member of staff to seek people's cooperation.

One staff member spoken with was aware that the use of a lap belt on a person's wheelchair could be seen as restraint. They knew that an application under DoLS had been made to ensure this was the least restrictive option for the person's safety. A nurse on duty was able to tell us who on their unit was subject to restrictions on their freedom of movement because they did not understand the risks involved in leaving the home. They understood when an application to deprive someone of their liberty would be required as did the management team. We noted that applications to deprive people of their liberty had been made to ensure decisions about their safety were taken lawfully. The outcomes from the authorising body were awaited.

People were supported to maintain their health and to seek advice about this when it was necessary. People told us that staff ensured health professionals were contacted if someone became unwell or there were concerns about their health.

A member of agency staff said they felt that care staff were good at spotting when someone's condition was deteriorating and reporting it to nursing staff so it could be followed up. Another member of staff explained in detail how they supported someone with their diabetes, which was 'brittle' and difficult to control. We saw that there was guidance displayed about what to do if the person's blood sugar was high or low. Records showed that the way the person's condition was managed was consistent with what the staff member told us and the guidance we had seen. For example, we found that the person's blood sugars were retested in accordance with the guidance when readings were excessively high. Advice was taken from emergency services and acted upon to manage this when it was needed.

We could see that advice about concerns for people's health and welfare was taken from the dietician, GPs, speech and language therapy, mental health services and emergency services as required.

Good

Is the service caring?

Our findings

A relative of someone living with dementia said that they had not yet been involved in an assessment or review of the person's care plan. They said they had not expected to be involved at this stage as the person had only been in the home since November. However, they went on to say that a staff member would be supporting the person and them, at a forthcoming review with commissioners regarding the person's needs and placement. Some of the care plans we reviewed showed that people and those who were important to them, had been involved in developing them and making decisions about their care. The new management team recognised there was scope to increase this and intended that involving people more in decisions should be the next stage of the process, after care records had been updated.

Staff had developed positive and caring relationships with the people they were supporting. They spoke warmly and enthusiastically about the people living in the home.

People who were able to tell us made positive comments about the way that staff supported them. For example, one person said, "They [staff] are good." Another told us, "I like living here." A third person commented, "They [staff] keep their temper here, which I feel is important." A visitor told us that they felt that staff showed kindness to the people they were supporting. A relative we spoke with said that the person they visited had got to know the staff and was very settled living in the home. We found that a recent written compliment to the service said that there was, "…A great team of caring staff. The home is rightly to be recommended." Staff and visitors to the service said that, if they were in a position of not being able to care for a person at home, they thought they would receive good care at Swanton House.

We observed that a staff member engaged someone living in the home in discussion about things that were of interest to them, including animals and vehicles. They skilfully drew other people into the conversation, encouraging social interaction. We also observed a staff member engaging a small group of people in conversation about their favourite films and books. During these conversations there was a lot of laughter and smiling.

Throughout our inspection we noted that staff made eye contact with people and gave them time to respond. Where appropriate, they offered reassurance promptly when people became distressed. Sometimes staff distracted people from what was worrying them so that their anxiety was diminished. We saw that one staff member intervened to offer reassurance when someone was anxious about where they should be and said, "Sit down here with me." We observed that the person concerned regularly sought out the staff member and was reassured by knowing where the staff member was.

People were treated in a way that promoted their privacy and respected their dignity.

Two visitors to the service told us that staff were respectful of the people they had come to see. Two people living in the home told us that they felt the staff were polite and respectful of them. We observed that staff always addressed people by their name. We checked with some people and found that staff were using their preferred name rather than their given name, as documented in their records.

The registered manager was aware of how one person could distress others with whom they were living. They were monitoring the situation so that they could be sure the emotional needs of all parties were being met and take action if this was not the case.

We saw that staff knocked on people's doors before entering their rooms. People who needed assistance with personal care were given this behind closed doors. We saw that it was important to one person's self-esteem to have their nails painted. This had happened and they showed us the polish.

We observed that one person was encouraged to maintain their independence and do as much for themselves as they could. They received prompting and offers of occasional assistance from staff to complete what they were doing but their independence was promoted. Staff respectfully praised and complimented them on their achievement. Staff were able to describe to us how one person's ability to do things independently could fluctuate. However, they were clear that they always encouraged the person to do what they could for themselves before offering practical assistance.

Visitors to the home said that they could come when they wished and join people for meals. We saw that they were welcomed into the home by staff. One visitor described staff as "…courteous…" to both themselves and the person they had come to see.

Good

Is the service responsive?

Our findings

People were offered support that was flexible and took into account their individual physical, emotional and social needs and how these changed on a daily basis.

People told us that they were satisfied with the way they were supported and their needs were met. For example, one person said, "They look after you well. They help to keep me clean." A visitor told us how they felt staff were, "…good with personal care." We noted from one person's records that they had been offered support to shower on a day that was not part of their usual routine. They had declined the assistance because it was not, "…my day." Their decision had been respected and staff had offered reassurance they could have a shower when they wanted to.

Staff were able to tell us about people's health and welfare as well as their individual needs and preferences. They were able to describe the support they were expected to offer. The information they gave us was consistent with what we saw in people's care records.

We noted from a discussion between two staff members that they were aware of one person's particularly complex needs, including in relation to their mental health. They were clear about how they were expected to intervene to support the person. This included giving the person time to make their own decisions and not over-loading them with options. Their discussions showed that they recognised the need to tailor their approach and the support they offered, according to changes in the person's mood, anxiety or behaviour. They were also aware of the person's background, history and what was important to them.

People's care plans and risk assessments had undergone several changes in record keeping systems. However, staff said that they felt the latest system was working better and understood why changes had been necessary. We noted that information within care plans indicated the frequency with which they should be reviewed to keep them up to date. We noted that there was variable practice in this area, with some information not being updated and reviewed in a timely manner. However, there had been a recent audit of care plans by the management team which highlighted the action necessary to ensure they remained relevant to people's current needs.

People who were able to tell us were satisfied with the way the service met their recreational and social needs. One person told us, "I do get fed up sometimes but I would do that at home anyway. I can go to my room and listen to the radio." They told us that they did not like to go out very often. Another person said, "There's always something going on. There's a minibus so we can go out all over the place."

A visitor told us how the person they came to see had spent much of their working life outdoors. They said that the person really enjoyed being able to access the grounds outside their room independently and felt this had contributed to their wellbeing. We saw that, in two of the units, people chose to spend some of their time sitting or walking in the gardens. The management team told us how there were plans to improve the safety and accessibility of the grounds outside the main home. This would contribute to people living in that unit being able to more freely, easily and safely access the fresh air.

We saw that, in the main home, staff engaged a small group of people in a ball game to help them exercise from their armchairs. During this, they encouraged interaction between people. They took into account one person's expression that they no longer wanted to join in. They spent time afterwards engaging people in conversation about a future planned activity. This related to a 'Zoo' group who brought in a variety of animals for people to learn about and handle if they wished.

There was a new activities coordinator in post to help improve support for people with their hobbies and interests. That staff member told us how they were pleased with the budget that had been allocated for them to fund a programme that would meet people's recreational and social needs. They also confirmed that care staff were allocated to provide additional support for these activities. We noted that they had started identifying with people what their past and current interests were so that they could tailor activities accordingly. The staff member told us how a separate log cabin was available for people to engage with one another in small groups, away from call bells and the bustle of the home if this was appropriate. Two staff told us how a poly-tunnel on the site had captured the interests of one person who had started to clear this and wanted to grow plants.

During the first day of our inspection a group of people enjoyed an outing to the seaside and a café. During the second day, a group of people went sailing. We saw that, on their return to the service, people were smiling and enthusiastic about where they had been.

People or their representatives, were confident that any concerns or complaints would be taken seriously and followed up.

People we spoke with said they were not sure who they would speak to if they had a complaint and could not remember seeing information about making a complaint. However, they told us they did not have any concerns. A visitor told us they were confident that staff, "…would listen and take things on board. If not I would put it in writing. [The manager] keeps a close eye on things." Another visitor told us they were not clear about the formal process for making complaints. However, they said that they would speak to, "… Whoever is on duty. I'm sure that they would listen. I'd be confident they would do something about it. I haven't had anything I've needed to raise."

Information provided by the manager showed that there had been no recent complaints about the service, concerns having last been raised in February 2015 about staffing levels.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection of this service, in April 2014, minor concerns were identified for the way that records were maintained and updated. Some lacked detail about the needs of people and the registered manager at that time indicated the care plan system would be revised. At this inspection, we found that action had been taken to revise the care plan format. Risks to people's safety and welfare were assessed. There was guidance about what staff needed to do to support people safely.

The provider could not demonstrate stability and consistency of leadership within the service to ensure that improvements were identified, made and sustained.

Our records show that there had been four changes in the management arrangements at the home in the year before our inspection. Leadership within individual units on the site had also changed and the staffing structure within the service had been revised. Some staff had been made redundant and others had to reapply for slightly different job roles. The most recent change to the care team, involving appointment of team leaders and abolition of senior carer roles, was implemented on 1 April 2016.

Staff expressed clear frustration with the lack of stability of leadership they had experienced and how this had impacted upon the way they worked. For example, staff said that each change resulted in an alteration to recording systems and then it would often be changed again when yet another manager arrived. They said that this had made staff feel disillusioned, fed up and that morale had declined as a result.

There was a lack of clarity from the provider about the nature and purpose of the service and the types of needs people were expected to present when they were admitted. They had not taken action to address this development in the way the service was described to the Care Quality Commission (CQC), and in information on the website for Swanton House.

Information lodged with CQC was that the home supported two 'service user bands'. These were for people with learning disabilities or autistic spectrum disorder, or mental health. This did not reflect our observations and discussion with the management team and presented a misleading picture of what the service was offering. Our discussions and observations indicated that many people living in the home needed support primarily as a result of age related conditions, including dementia. Some had a history of mental ill health but we were informed only one person had primary care needs relating to learning disability.

The home's website mentioned dementia care but this and 'older people' had not been added to the service user bands for the home. A previous website address remained logged with CQC and was not accurate. There was a discrepancy between the way the service was described and what was happening within it. The provider had failed to take action to ensure that the service was clearly and accurately described both to CQC and to the public.

We discussed the nature of the service with the registered manager. The manager undertook to make sure

the provider updated the statement of purpose and revised service user bands. The manager was aware that they needed to submit the information to CQC and ensure that a corresponding notification was submitted to CQC. The manager initiated discussions about this with the provider while we were completing this inspection to ensure appropriate action was taken.

The provider's systems for reviewing the performance of their services included analysing the numbers of adverse incidents and accidents taking place across their services so that trends could be analysed. They also looked at compliance with the provider's expected rates of completion of training and supervision. They compared the results across their services so that managers and regional managers could see how they were measured against the provider's other regions and services.

There had been a survey of people's family members and friends during 2015. These did not raise significant concerns but did show some areas of the service that respondents considered were adequate, rather than good or excellent. They also contained a number of suggestions for improvement. For example, one highlighted that staff morale and a lack of training was a problem. Another commented that there could be more involvement of people and families in developing care plans. These were reflected in the findings of this inspection. The new management team, including the new regional manager, had not yet had time to fully assess the home's performance and to ensure improvements were made and sustained.

The report from the commissioner's visit in March 2016 indicated improvements had been made within the service but there remained some concerns. These included improvements that were needed to the way the service showed people's needs for food and drink were being met. The current management arrangements had only been confirmed after the commissioner's visit. This recent change had not yet bedded in to ensure that improvements were made and sustained properly.

The current registered manager had been appointed towards the end of 2015 and completed registration with the Care Quality Commission (CQC) in February 2016. There had been changes in the provider's oversight of the service with a new regional manager in post for three weeks. The provider had transferred management staff from two of their other locations to Swanton House in December 2015 to provide additional support. The arrangements were initially intended to be temporary for three months but had been made permanent just before our inspection. These two members of the management team had only recently taken over responsibilities as unit managers to support the registered manager.

The new management team were able to tell us about the challenges they were experiencing and how they were prioritising areas for improvement. They had a shared vision for the improvements that were needed. Staff were also aware of developments taking place within the service. They told us they felt morale was improving again as a result of recent changes and had confidence in the current management team. This confidence was shared by a visiting health professional who knew the registered manager from another service.

Staff felt that the new management were open to their views and shared information with them. For example, staff told us that they understood why the current management team had changed records associated with care plans and progress notes. They were aware that this had been implemented as a part of streamlining care plans. Two staff members commented to us that it was a better and clearer process. The management team felt that the new system would mean staff would better understand how things related together when a proposed computerised system could be introduced.

The new management arrangements and staffing structure needed time to be bedded in to ensure that improvements would be made and sustained, taking into account the views of people living and working in

the home.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The service could not demonstrate that people, particularly those who were living with dementia, always received enough to eat and drink to ensure their health and wellbeing. Regulation 14(1),(2) and(4)(a)