Precious Homes Limited

Swan Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Swan Court is a care home providing personal care for up to eight people with a learning disability and or autistic spectrum disorder. At the time of our inspection there were seven people living at the service. Swan Court is a purpose-built accommodation and consists of eight flats that include a bedroom, lounge and bathroom as well as kitchens in some instances. There are also internal communal areas and a garden people can access.

Some parts of the service have been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

Swan Court was registered for eight people which is larger than current best practice guidance. The service was within a larger building which included a supported living service for people with learning disabilities. However, there was a separate entrance and garden and the location of the service enabled people to have easy access to the local community. Staff were also discouraged from wearing anything that suggested they were care staff when coming and going with people.

People's experience of using this service and what we found
Records were not consistently updated in response to incidents and changes in need. Some aspects of medicine management required improvement. Some systems in place to monitor the quality and safety of the service were inconsistent. Relatives were involved in decisions about people's care but there was limited action taken to gain their views on the service as a whole.

Relatives told us people were safe. Staff had received safeguarding training and knew how to escalate suspicions of abuse. Staff were recruited safely and there were sufficient staff to meet people's needs. Incidents and accidents were recorded, and action taken to mitigate the risk to the individuals involved. Relatives and staff spoke positively about the management at the service and staff felt supported.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 07 November 2018).

Why we inspected
We received concerns in relation to the safety and care provided to people by staff employed by the provider. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led

only.

We reviewed the information we held about the service. No areas of concern were identified in the other Key Questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well led sections of this report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Swan Court on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Swan Court

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was absent from the service but appropriate management cover had been put into place.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and clinical commissioning group who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with one person who used the service and three relatives about their experience of the care provided. We spoke with seven members of staff including the provider, manager, senior care worker and care workers.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including minutes of staff meetings and audits were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at policies and procedures and spoke to two relatives.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

● One person had a medical condition and needed specialist medicines given to them in an emergency situation. Not all staff were clear on the process of administering this medicine and two different protocols were in place at the service. Whilst staff confirmed they had received training in this area this had not been recorded. We raised this with the manager who ensured the correct protocols were in place.

● Liquid medicines we reviewed did not have a date of opening. This meant staff did not know when the medicine was no longer safe to use.

● When people required medicines to be administered on an 'as and when required' basis, there was not always enough guidance in place for staff to know when to give the medicines. Staff we spoke to knew the signs to look for but the service used agency staff and the lack of guidance increased the risk of people not having their medicines when required.

● The administration of people's medicines was recorded appropriately and medicines were stored safely.The amount of medicine stored within the service was regularly monitored to ensure all medicines could be accounted for and sufficient quantities were available to people.

Assessing risk, safety monitoring and management

● Care records were not always updated in a timely manner following changes in need. This meant guidance in place for staff did not always reflect the support people required. Staff we spoke with did have good knowledge of people's current support needs, but the lack of recording increased the risk of inconsistent care.

● Environmental checks were carried out to ensure people were kept safe, this included checks on water temperatures and safety equipment within the home. There had been a period when checks on fire equipment were not being routinely completed, however this had improved, and regular monitoring was now taking place.

● Staff we spoke with were aware of people's risks and were able to tell us how they supported them to keep safe.

Learning lessons when things go wrong

● Incidents such as safeguarding concerns and people demonstrating distressed behaviours were recorded and dealt with appropriately as and when they occurred. Although learning was in place from individual incidents there was no oversight in place to identify possible themes and look at how risks could be reduced further.

Systems and processes to safeguard people from the risk of abuse

● Relatives told us they felt people were safe and when safeguarding concerns arose they were reported. One relative said, "When an incident has happened they are open and contacted me immediately and contacted the authorities also." Another relative told us, "They are very good and try and de-escalate…they know what [person] needs to calm down."
● People were supported by staff who understood the signs of abuse and appropriate action to take should they have concerns. One staff member told us, "I would report concerns to management, if no progress I would take it further, go to CQC."
● Staff we spoke told us people were supported safely and had not seen anything to raise their concerns. One staff member said, "We put service users above everything else and ensure they have dignity and respect."
● Prior to the inspection a member of the public had raised concerns about the safety and care of people when staff were providing support. The manager had liaised with the local safeguarding authority and an investigation was carried out which concluded shortly after the inspection. This did not substantiate any of the concerns. The provider had also commissioned an external agency to look into the concerns. This was in process at the time of the inspection, but feedback at the time of the inspection confirmed no concerns had been found at that time. The provider confirmed they would share the full findings of this investigation with us once completed.

Staffing and recruitment
● Staff were recruited safely. Robust pre-employment checks were carried out to ensure staff were suitable to work with people who may be vulnerable.
● Relatives told us there were sufficient staff to meet people's needs. One person told us, "There is always a good number of staff on duty. Other staff can cover when one person get super excited or anxious."
● Agency staff were used to cover staff absence. A relative advised at times the use of agency staff had impacted on the consistency of care. The manager advised they used a specific agency to reduce the number of different staff and they were in the process of recruiting four permanent staff members.

Preventing and controlling infection
● Staff were able to tell us how they ensured good infection control standards and had access to personal protective equipment when supporting people.
● Daily cleaning of people's individual flats took place and this was recorded. One relative told us they had concerns in the past but had seen improvements in the cleanliness of the environment. They told us, "Over the last two to three months there has been an improvement. [Manager] is quite hot on the cleanliness side of things."

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Systems in place to ensure medicines were safely managed needed improvement. A weekly medicine audit was in place, but this hadn't identified the concerns we found on inspection in relation to liquid and 'when required' medicines protocols. Where systems had identified areas for improvement they had not always been addressed in a timely manner. For example, four medicine audits in December had highlighted missing signatures on the list of staff trained and competent to administer medication. No follow up action had been taken to address this.
- Systems had failed to address a period of six months were there was no records of certain fire equipment being checked. We discussed this with the manager who advised this had occurred due to difficulties with senior staffing. Whilst we saw regular checks had begun again this could cause a risk if the situation with staffing arose again.
- Governance systems had not always been effective in ensuring risk assessments and care plans were up to date following incidents and changes in people's needs. Although staff were aware of people's needs, the lack of recording increased the risk of inconsistent care particularly as the service used agency staff.
- The managers understood the regulatory requirements associated with their roles and had ensured these were met. Notifications had been submitted to CQC when needed as required by law.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Although relatives told us involvement was very good in relation to the individual care of people, there was limited involvement with decisions and information about the service as a whole. The last annual surveys completed with families was September 2018 and there were no regular meetings or other ways to gather their views. Two of the relatives told us they would welcome more involvement. The manager advised another survey had been sent out recently and they would look into different ways to involve families more.
- There were staff meetings for staff to share their views of the service and annual staff surveys were completed. Staff we spoke with felt they were able to raise concerns, and these would be listened to and addressed.
- People's care records included information about what was working well for people and what wasn't working and the action taken in response to this. This included the views or observations from the person's point of view as well as staff and relatives.

Continuous learning and improving care

● Although incidents were recorded and measures put in place to reduce risk and improve the quality of care for people, there was no oversight or analysis of the incidents within the service. This meant the opportunity to look at themes and trends and improve care in response, was missed. We raised this with the manager who advised they would address this concern.

● The provider was in the process of employing senior care staff to work at nights. This was to give a greater oversight of the quality of care and improve the support available to staff.

● The provider was putting in place a number of developments to improve their services. This included a new induction and training programme for managers and increasing their internal multi-disciplinary team so more support could be offered when people where showing distressed behaviours.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● Staff and relatives spoke positively about the management at the service and felt able to raise concerns. A relative told us, "Any concerns I'm on the phone, they are always willing to speak to me."

● We saw the manager responding to staff's request for support for a person who was appearing anxious.

● The provider had taken steps to address the concerns raised by CQC to ensure people were receiving safe care from staff. The management team had investigated the concerns and completed unannounced spot checks to ensure people were safe. They had also asked an independent company to look into the concerns. This demonstrated the provider had taken the concerns seriously and were taking steps to ensure people were safe.

Working in partnership with others

● The provider worked in partnership with other professionals and agencies, such as psychiatrists and social workers. A visitor involved in someone's care told us there was good communication with the service.