Swindon Borough Council

Swindon Family Breaks Service

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
Swindon Family Breaks Service provides short break services to people with learning disabilities, and supported living to people in specially designed bungalows and people's own accommodation in Swindon The short break service is registered to provide accommodation and personal care for up to 14 people. There were four people using short break services during our inspection. There was one person receiving the regulated activity of personal care in the supported living service during this inspection.

Not everyone using the service received personal care. CQC only inspects where people receive personal care, which is help with tasks relating to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Right support:
People's care plans were not always up to date and did not always reflect their current needs. The service gave people care and support in a safe, clean, well equipped and well-furnished environment. However, certain health and safety checks had not been completed in line with the provider's policies. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. Staff supported people to take part in activities and pursue their interests in their local area and to interact online with people who had shared interests. People were protected from the risk of infection. People were treated with dignity; their privacy was respected and they were supported to be as independent in their care as possible.

Right care:
People's care, treatment and support plans did not always reflect their range of needs and this did not always promote their wellbeing and enjoyment of life. Staff understood how to protect people from poor care and abuse. However, systems to protect people from abuse required improvement. People could communicate with staff and understand information given to them because staff supported them consistently and understood their individual communication needs. People who had individual ways of communicating, using body language, Makaton (a form of sign language), pictures and symbols could interact comfortably with staff and others involved in their care and support because staff had the necessary skills to understand them. The service had enough appropriately skilled staff to meet people's needs and keep them safe.

Right culture:
People and those important to them, including advocates, were involved in planning their care. The service enabled people and those important to them to work with staff to develop the service. Staff valued and acted upon people's views. Staff ensured risks of a closed culture were minimised so that people received support based on transparency, respect and inclusivity. Staff placed people's wishes, needs and rights at the heart of everything they did.

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

Rating at last inspection and update
The last rating for this service was good (published 30 March 2018).

Why we inspected
We received concerns in relation to a safeguarding incident and end of life care. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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

You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified a breach in relation to safe care and treatment at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Swindon Family Breaks Service

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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by three 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.

Service and service type
This service provides care and support to people living in 'supported living' setting, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

Swindon Family Breaks Service is also a 'care home' providing respite service. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Swindon Family Breaks Service is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

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 used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with three people using the service, four relatives, three members of staff and the registered manager'. As some people were unable to communicate with us verbally, we used Makaton to obtain their opinion. Makaton is a unique language programme that uses symbols, signs and speech to enable people to communicate. We reviewed a range of records. This included four people's care records and various medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures, were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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.

Assessing risk, safety monitoring and management

● People's care records did not always help them get the support they needed because not all care records were up to date. For example, one person's epilepsy protocol had not been reviewed since 2016 and contained out-of-date information about the person's medicines. We brought this to the attention of the registered manager who updated the person's epilepsy protocol.

● Some of the information in care records were not always accurate. For example, one person's epilepsy protocol stated they needed to be checked on every 30 minutes, however their risk assessment stated the checks were to be completed every 15 minutes. Staff interviewed told us the person was to be monitored on a 15 minutes basis, however, records showed the person was monitored every 30 minutes. This posed a risk that a potential seizure could be missed and not recorded by staff. We brought this to the attention of the registered manager who told us they were going to update the person's care plan and risk assessments.

● Staff did not always manage the safety of the living environment and equipment in it through checks and action to minimise risk. The provider had not ensured all health and safety checks were carried out as per the provider's risk assessment. For example, a fire drill was supposed to take place every three months. However, only one fire drill was recorded for 2021 and one fire drill for 2022. This placed people at risk as the provider could not ensure people and staff would be evacuated safely in case of fire. We brought this to the attention of the registered manager who included this in their action plan.

● We found that although the provider had a 'read and sign' system in relation to care plans and risk assessments, not all staff signed the document to confirm they were familiar with people's care plans. We found that one person had been supported by some staff members during the day that had failed to sign the 'read and sign' document. No member of night staff supporting the person completed the 'read and sign' form to indicate they were familiar with the person's care plan. As a result staff did not always follow appropriate guidance when working with the person. This placed the person at risk of avoidable harm. We brought this to the attention of the registered manager who told us they were going to address this issue with staff.

The provider had failed to do all that was reasonably practicable to mitigate risks to people. This is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● We could not be assured people were protected against the risk of abuse. The provider had no effective system in place that could provide staff with information about their responsibilities and where to escalate their safeguarding concerns. Although staff interviewed knew how to report their concerns, there was no system to inform new or agency staff of appropriate systems of escalating safeguarding concerns. We raised

this with the registered manager who included this in their action plan following our inspection.

We recommend that provider introduces appropriate systems of escalation safeguarding concerns internally and externally and ensure all staff including agency staff are aware of those processes

● Most people and their relatives told us they felt safe using the service. One person told us, "I feel safe." Another person indicated using Makaton they felt safe. However, one person's relatives told us they did not feel reassured the service was safe following a recent safeguarding incident. The relative told us, "I was mortified by what I found and [person] hasn't been the same since."
● Staff had training on how to recognise and report abuse and they knew how to apply it. A member of staff told us, "I would report to the management, complete a body map; if the manager didn't respond, I would go to a safeguarding 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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions relating to DoLS authorisations were being met.

Staffing and recruitment
● Staff recruitment and induction training processes promoted safety, including those for agency staff. The numbers and skills of staff matched the needs of people using the service.
● The service had enough staff, including for one-to-one support for people to take part in activities and visits how and when they wanted. At the time of the inspection the service was using agency staff to fill staffing levels with staff members who were already familiar to people.
● People, their relatives and staff told us there were enough staff to support people safely. A staff member told us, "Staffing levels are ok, we do use agency due to Covid or if people are off sick."

Using medicines safely
● People could take their medicines in private when appropriate and safe. People were supported by staff who followed systems and processes to prescribe, administer, record and store medicines safely.
● Staff followed national practice to check that people had the correct medicines when they moved into a new place or they moved between services.
● The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) and ensured that people's medicines were reviewed by prescribers in line with these principles.

Preventing and controlling infection
● The service prevented visitors from catching and spreading infections.

- The service followed shielding and social distancing rules.
- The service admitting people safely to the service.
- Staff used personal protective equipment (PPE) effectively and safely.
- The service tested for infection in people using the service and staff.
- The service used effective infection, prevention and control measures to keep people safe, and staff supported people to follow them. The service had good arrangements for keep premises clean and hygienic.
- The service prevented visitors from catching and spreading infections.
- People were able to receive visitors as per government guidance.

Learning lessons when things go wrong

- The service did not always manage incidents affecting people's safety well. Staff recognised incidents but did not always report them appropriately. The registered manager investigated incidents and shared lessons learned.
- When things went wrong, staff apologised and gave people honest information and suitable support.
- Following our inspection, the registered manager implemented changes to ensure lessons were learned when things went wrong.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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

- Governance processes were not always effective and did not always hold staff accountable, keep people safe, protect people's rights and provide good quality care and support. The quality assurance systems and processes in place had failed to identify and correct the issues we found at the inspection.
- Staff were committed to reviewing people's care and support on an ongoing basis as people's needs and wishes changed over time. However, some staff had not read and understood risk assessments and care plans prior to delivering care and support to a person with complex needs.
- Senior staff did not always understand and demonstrate compliance with regulatory and legislative requirements. The provider's environmental audits had not been completed in line with their policies. The shortfalls in these audits had not been identified until this inspection.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The registered manager set a culture that valued reflection, learning and improvement and they were receptive to challenge and welcomed fresh perspectives.
- Staff felt respected, supported and valued by senior staff which supported a positive and improvement-driven culture. Staff felt able to raise concerns with managers without fear of what might happen as a result.

- The management were visible in the service, approachable and took a genuine interest in what people, staff, family, advocates and other professionals had to say. They clearly wanted to learn and improve from other health and social care professionals.

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

- The provider met their responsibilities in relation to duty of candour where they had identified failings. Duty of candour requires that providers are open and transparent with people who use services and other people acting lawfully on their behalf in relation to care and treatment.
- The service apologised to people, and those important to them, when things went wrong
- Staff gave honest information and suitable support, and applied duty of candour where appropriate.

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

● The provider sought feedback from people and those important to them and used the feedback to develop the service. Most people's relatives praised communication within the service. One person's relative told us, "The carers will phone straight away if there is any issue, even to say if they are going to be a bit late."
● Staff gave positive feedback about the service and the care provided. Staff's views were regularly sought through team meetings and monthly supervisions. A member of staff told us, "I feel supported, we have regular supervisions and meetings,"
● People, and those important to them, worked with managers and staff to develop and improve the service. Comments from people's relatives included, "The staff are polite and helpful and always listen to my concerns" and "The staff are always welcoming and friendly."

Continuous learning and improving care; Working in partnership with others
● The registered manager demonstrated a willingness to provide good quality care to people. They started making improvements following our inspection feedback.
● The service worked well in partnership with advocacy organisations, other health and social care professionals, which helped to give people using the service a voice.

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 Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess the risks to the health and safety of service users of receiving the care or treatment. The provider failed to ensure that the premises used by the service provider are safe to use for their intended purpose.