Heritage Care 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 effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Swan Court consists of 12 apartments for older people. The accommodation is part of the 'Extracare' service offered by Heritage Care. Heritage Care provides support and personal care to people living at Swan Court in their own flats. At the time of this inspection, nine people were living at Swan Court.

Swan Court has a registered manager in place. The registered manager was also the registered manager of the sister service, Swan House, which is linked to Swan Court. 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. We undertook an announced inspection of Swan Court on 15 February 2017.

People told us they felt safe at Swan Court. Staff understood their responsibilities in relation to safeguarding people. Staff knew how to keep people safe. One staff member said "When people are in our care, they should be safe in every aspect of their life and not under any threat of abuse". Staff received regular training to make sure they stayed up to date with recognising and reporting safety concerns. The service had systems in place to notify the authorities where concerns were identified. People received their medicine as prescribed.

People benefitted from caring relationships with the staff. People said "Staff are very good, no problems. They are kind and respectful" and "They are such a good team, I don't need to ask them anything". People were involved in their care choices and people's independence was actively promoted. People and staff told us people's dignity was promoted.

Where risks to people had been identified, risk assessments were mainly in place and action had been taken to manage these risks. Staff sought people's consent and involved them in their care where possible.

There were sufficient staff to meet people's needs. Staff rotas confirmed planned staffing levels were maintained. The service had safe recruitment procedures and conducted background checks to ensure staff were suitable to undertake their care role.

People said they were happy with the level of support and care from staff. One person said "My care flows along and I am happy here". People's nutritional needs were met and they told us they were well supported where needed with their meals.

People told us they had no complaints and were confident they would be listened to and action would be taken if they raised a concern.

The service had systems to assess the quality of the service provided, but these were not always effective. Systems were in place that ensured people were protected against the risks of unsafe or inappropriate care,

but records of incidents were not always maintained.

We have made a recommendation that staff are reminded of their responsibility to record all incidents.

Staff spoke positively about the support they received from all of the team at Swan Court. Staff supervision and other meetings were scheduled for 2017, but formal supervisions had not taken place as planned in 2016. People and staff told us all of the management team were approachable and there was a good level of communication within the service.

We have made a recommendation that staff supervisions be formally recorded.

People told us the team at Swan Court were very friendly, responsive and well managed. The service sought people's views of their care.

We found the provider was in breach of one regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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?

Requires Improvement

The service was not always safe.

People and visitors told us people were safe. Staff knew how to identify potential abuse and raise concerns.

There were sufficient staff deployed to meet people's needs and keep them safe.

Risks to people were identified and risk assessments were mainly in place to manage the risks. Staff followed guidance relating to the management of risks, but staff did not always record incidents.

People had their medicine as prescribed.

Is the service effective?

Good

The service was effective.

People were supported by staff that had the training and knowledge to support them effectively.

Staff received support and had access to further training and development.

People had access to healthcare services and people's nutrition was well maintained.

Is the service caring?

Good

The service was caring.

Staff were kind, compassionate and respectful and treated people with dignity and respect which promoted their wellbeing.

Staff gave people the time to express their wishes and respected the decisions they made. People were involved where possible in their care.

The provider and staff promoted people's independence.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed prior to moving into Swan Court to ensure their needs could be met.

Care plans were personalised and gave clear guidance for staff on how to support people.

People knew how to raise concerns and were confident action would be taken.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service had systems in place to monitor the quality of service, but these systems were not always effective. Incidents were not always recorded to ensure people's safety was maintained.

There was a positive culture, people and staff felt the management of the service was good.

Swan Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 16 January 2017 and was announced. We gave the provider a weeks' notice as we intended to speak to people as a group that lived at Swan Court and we wanted the provider to liaise with people and arrange the meeting. The registered manager and the care team leader who was responsible for the day to day running of the service were not available on the day of our inspection. We were assisted on the day by another care team leader who had previously worked at Swan Court but had moved to the sister service, Swan House.

The inspection was carried out by one inspector 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 the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the information we held about the service. This included notifications about important events which the service is required to send us by law.

During the inspection we spoke with seven people who used the service. Five through our group meeting in the communal lounge and two people in their own flats. We also spoke with one visitor from the voluntary sector.

We looked at three people's care records, medicine administration records, staff records and records relating to the general management of the service. We spoke with the care team leader from Swan House, four care staff in person or by phone and received feedback by email from another care staff member. We also spoke with Heritage Care's, Head of Buckinghamshire Services.

Requires Improvement

Is the service safe?

Our findings

Systems were in place to record accidents and incidents and actions were taken to prevent these reoccurring. For example, one person told us of an incident which had obviously upset them. We discussed this with the care team leader and they told us how they had taken action to protect this person's health. They said that when explained to the person the reason for the action, the person understood, but at times, did need reminding to prevent any anxiety. However, not all incidents had been managed safely.

One person told us of an incident where someone from the adjoining Swan House had entered their flat. The person was in a state of undress and had entered this person's flat around midnight. They said they called for assistance from staff and the person was safely managed and returned back to Swan House. This had upset the person in Swan Court and they reported this to us when we met them at the inspection. They told us this incident was at the end of last week, which would mean it may have occurred a few days before our inspection, possibly on Saturday 11 February 2017. Staff were aware of the incident and told us the action they took. It was unclear how the person from Swan House had accessed Swan Court. The care team leader thought this person may have forced the adjoining door. However, this door had a key code to ensure secure access. On the day of our inspection we tried this access door and found it to be insecure. We reported this to the care team leader who arranged for the door to be made secure immediately. However, our inspection was four days after this incident. We were told by staff of another incident where they found a person in Swan Court on 7 February 2017. They told us they discovered this person when on the afternoon shift. This person was escorted to Swan House where it was discovered they were a resident there. We asked if checks were carried out by staff to ensure Swan Court was secure. Records were provided which showed staff had checked the access door between Swan House and Swan Court each day. The records were signed to say the door was secure. It was therefore not clear why the door was found insecure on the day of our inspection.

We discussed these incidents with the care team leader and the Head of Buckinghamshire Services for Heritage Care on the day of our inspection. They told us they would look into the incidents and establish how this person had accessed Swan Court from Swan House. They told us that staff did not use this access door as it disturbed the tenant in the flat close by. Therefore there should have been no issue with the security of the door. No incident form had been completed by staff to record these occurrences and there was nothing recorded in the 'handover' book to inform staff. Robust methods were not in place to record incidents and records of security checks had not identified the risks associated to people who lived at Swan Court as the insecure door had not been identified. This meant people's safety may be compromised as staff had not followed procedure.

We recommend the provider ensures all staff are aware of their responsibilities to record any incidents or accidents to enable people's safety is protected.

Other risks to people's safety was maintained. For example, weekly fire alarm checks were carried out at Swan Court. We also saw that corridors at Swan Court were monitored by CCTV which ensured staff were able to monitor people and visitors movements. People's care plans contained risk assessments which

included risks associated with: falls; nutrition; pain; medicines and manual handling. Where risks were identified care plans were in place to ensure risks were managed. For example, where peoples were at risk of falling, plans were in place to maintain their safety by assisting the person to have their furniture in a safe place to prevent any trips. However, we saw one person was at risk of seizures due to their health condition. There was no risk assessment for this condition on this person's paper file or electronic file. This meant staff may not be aware of how to manage this person's health condition safely.

People told us they were safe. Comments included; "Safe, I have not issues, I can go as I please"; "I have confidence in the staff"; "It's good here, I feel safe, secure and looked after" and "I feel safe here, no one has come in to my flat that I was not expecting". A visitor we spoke with on the day told us they felt people were safe at Swan Court.

We saw people had access to equipment to keep them safe and to call for assistance where necessary. For example, people either wore pendants or wrist alarms. Some people who visited the community, had wrist alarms which could be activated if away from Swan Court. Staff told us this gave them 'piece of mind' when this person was out in the community. They also gave us examples how the community supported people to keep people safe. For example, one person frequented a local public house. Staff said the staff at the pub would give Swan Court a call when the person got their taxi to return to the service so that people were kept safe.

Swan Court staff looked after people's money. We saw systems were in place to effectively manage people's money safely. We saw receipts were obtained to confirm how people's money was spent and cash balance checks were maintained. We looked at two people's records and found robust systems were in place to manage people's money and the money held at Swan Court agreed to the records held by the service.

Staff had completed safeguarding vulnerable adults training. Staff we spoke with were able to tell us about the different types of abuse and the signs that might indicate abuse. Staff had a clear understanding of their responsibilities to report any concerns and were aware of which outside agencies they could report to as well as their own management team. Staff said, "Safeguarding is put in place to protect tenants that we look after. If concerned, I would go through the appropriate steps, report it to the care team leader and take if further externally if I was not happy." and "It's to protect tenants from harm or abuse". We saw information was available for staff to follow regarding safeguarding concerns. For example, a flow chart of actions to take and contact details were displayed at Swan Court.

We saw systems were in place to record safeguarding concerns. The provider had reported concerns to the relevant authorities, including the Care Quality Commission.

Staff told us they were aware of the provider's whistle blowing policy. Whistleblowing is where someone can anonymously raise concerns about standards of care. One staff member said "I would definitely not hesitate to 'whistle blow' if I had concerns".

Arrangements for emergencies were in place. We saw people had individual personal emergency evacuation plans (PEEPS). These were stored securely next to the fire panel in the reception area in Swan House. We saw a box which contained people's PEEP's, emergency equipment and a copy of the up to date fire assessment. This ensured details were available to emergency staff when needed.

People told us they felt there were usually enough staff to meet their care and call needs at Swan Court. Comments included "They come when I need them to"; "They see me when required" "I have had not missed calls"; "The staff are never rushed when they come to see me"; "They have time to make me a cup of

tea, not rushed" and "They will come at short notice if I need them to". One staff member said "At the minute yes there are enough staff, but when the other flats are filled, we will need more". One staff member said "We always have enough staff to care for people, even when let down by agency as permanent staff work to cover the shifts".

Staff told us that the agency or bank staff used were the same staff to ensure continuity for people. We spoke with two bank staff and they told us they regularly came and supported people at Swan Court. They also confirmed they felt there were enough staff to meet people's needs.

Records relating to recruitment of staff contained relevant checks that had been completed before staff worked unsupervised in the home to ensure they were of good character. These included employment references and disclosure and barring checks (DBS). DBS checks enable employers to make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

Staff told us about their recruitment process. They completed a job application form, underwent an interview and had to produce identification details, for example, a passport. They were also underwent health checks.

We saw people had guidance in their care plans of how their medication should be given. However, these details did not contain full guidance of how to administer topical medicines or in some files, PRN (medication as required). We discussed this with the care team leader who said it was an oversight and we saw immediate action was taken by the provider and evidence of these changes were implemented and added to the guidance in people's care files.

Safe systems were in place to manage people's medicines. We saw the staff who were about to administer medicine checked the electronic care plan system and the written records to ensure it was safe to give people their medicines. For example, there was enough time between this administration and the previous medicine administered. We observed the medicine round with one of the staff members and visited three people in their flats to observe administration of their medicine. The staff member was diligent, wore gloves to minimise cross infection and approached people in a calm manner. For example, they encouraged people to take their medicines and were patient, supportive and did not rush people. We saw people's medication administration records (MAR) were completed appropriately. People had lockable cabinets in their flats to store their medicines. Keys were held securely by the staff team at Swan Court. We were told no one had medicine which required to be stored in a fridge. If people did, staff told us these were held in a lockable box in the fridge in their flat. People told us they received their medicine when needed.

Good

Is the service effective?

Our findings

Staff had the skills and knowledge to meet people's needs. Staff had completed training which included; moving and handling, medication, health and safety infection control, dementia care and Mental Capacity Act 2005 (MCA).

Staff were complimentary about the training provided and were able to request any additional training they felt would improve their skills and knowledge. They told us "Training has improved since I started".

People told us they felt staff had the necessary competency to care for people. Comments included, "Staff know what they are doing, always very helpful to me"; "Whatever I want they try their best to do it"; "They help me as well as they can"; "They know how to look after me, naturally some are better than others"; "Things I want to happen, do happen" and "I get the support I am supposed to have".

New staff completed an induction and were supported by more experienced staff until they felt confident to work alone. One staff member told us they had a two day induction at Swan House, before moving over to Swan Court. They completed their induction booklet and completed their training and were supported by senior staff at Swan Court to familiarise themselves with the people that lived there. They were also supported to complete the Care Certificate. This is a recognised qualification and set of standards for care staff. Other staff told us how they used care plans and training as tools to prepare them for their role. This included scenario tests before working with people alone. We were told by the staff we spoke with that they had observational checks as part of their competency, for example medicine administration.

We saw communication processes were in place to keep staff up to date. Handover meetings took place at the changeover of each shift. We observed the handover on the day of inspection. We saw records of these meetings where staff were provided with updates regarding individual people's needs. For example people's health needs, people's nutrition and personal care.

Staff told us they felt well supported by the care team leader at Swan Court but that they did not receive regular formal supervisions. Comments included "I have not had a supervision for about four or five months" and "I have not had regular supervisions, although I have had informal chats with management who are available if I have any questions". We were told and saw that staff had not had a formal one to one meeting since October 2016. This was when there had been a changeover of care team leader at Swan Court. We saw that supervisions were planned on a spread sheet displayed in the office for staff in 2017; however these had not been completed as planned. We were told these had not taken place due to the absence of the care team leader.

We recommend that provider arranges formal supervision, as per their policy, in the absence of the care team leader at Swan Court.

People's consent to care and treatment was obtained. We saw care files contained signed documents to confirm this, for example, consent to medicine administration by the team at Swan Court.

People were supported in line with the principles of the Mental Capacity Act 2005 (MCA). 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.

We saw people's capacity had been assessed in their care plan. People were supported to make decisions on their day to day care. Care plans outlined whether people had capacity to make decisions on care and treatment, and where appropriate a Lasting Power of Attorney was in place which had been authorised in accordance with the MCA. The management team demonstrated a clear understanding of their responsibilities in relation to MCA.

We spoke with staff about their understanding of the MCA. They told us, "I know that [name] has full capacity, but [name] may struggle with some decisions, for example their breakfast or personal care and need prompting". We confirmed their understanding by looking at the individual care files of people. Another staff member said "Basically it's a test to see what they can and cannot make decisions about".

We were told some people had brought in pre prepared meals which could be heated through and other people like to cook. People told us they were supported well with their nutrition. They said staff assisted them to heat their meal and encouraged them to eat. Comments from people included "They (staff) will put them in the oven for me"; "We have fish and chips in the lounge on a regular basis and we all eat together" and "I have put weight on and the doctor is pleased".

People had access to health professionals when required. People's care plans showed people had been supported to see health professionals, for example their GP. We saw people were not only supported with their health care needs by staff, but also from professionals. For example, people who had diabetes had their blood glucose levels regularly checked. Staff knew that people had to wait until this test had taken place before they had their breakfast. We saw records which showed how staff had assisted people to have their breakfast following their glucose check. People's comments included, "They get the GP if I am not well"; "The nurse comes and checks my insulin levels" and "If there are any health issues, the GP is called or they obtain advice from the GP".

One staff member told us how they had assisted one person with support for their eye sight. They said they had arranged for the person to get new glasses. This person now wanted support with their hearing and the staff member had been in contact with the GP to arrange and appointment.

Good

Is the service caring?

Our findings

People and visitors told us staff were caring. Comments included, "Care staff are excellent to say the least"; "Staff are very polite"; "They (staff) always care"; "They are considerate, help when you need it and all very nice"; "Care staff are excellent, very good"; "The staff are very good, always very nice to me; if not I would tell them" and "They are sympathetic and come to help". One person told us how important their relationship with staff was. They said they used to sing with one of the staff members and have fond memories of this. Another person told us how one staff member regularly supported them as they helped them walk up and down the corridor for a change of scenery and to keep me mobile". One visitor said "The staff are very polite, always pass messages to me. They do a really good job, never rude or 'out of hand' with anyone. I would use the term, 'friendly respect. From the care I see here, I would not mind being here myself".

Staff knew the people very well. One staff member told us how one person needed a lot of encouragement to look after themselves. They said "It's taken months for them to trust me, I got [name] a shower seat so he felt more safe". Other comments from staff included "All people are different, there are different ways of approaching people"; "I look at the situation and assess how best to support them" and "I love care work, it's what I like doing. I like to be able to help others, gives a sense of meaning, they (people) get everything they need".

Staff knew how important choice and independence was for people. Staff said "[name] has a different time to go to bed, I still give them the choice and ask if they still want to go to bed at this time"; "I know [name] prefers female care staff only"; "I coax people but still give them a choice, for example, to have a shave or not" and "I encourage [name] to do it themselves, otherwise they would let you do it for them, it's important to encourage their independence". We saw care plans were written with the involvement of the person where possible. People told us "I am involved in decisions about my care, they come and help me, but if I don't need it, they will watch me to ensure I am safe"; "Staff encourage me to be independent"; "If I don't want to go to the lounge, staff respect this and I can chose to stay in my flat".

Where people did not have a family member, an advocacy service was available for people. There was a group called 'The Owl Guardians'. People and staff told us they offered a support service for people, for example, with their finances. One person told us they wanted their washing machine plumbed in. We spoke with staff who said they would arrange this with the person's advocate.

People's dignity and privacy was respected. When staff spoke about people they were respectful and they displayed genuine affection. The language used in care plans was respectful. Staff explained how they promoted people's dignity. We saw staff rang people's door bells or knocked on their flat door before entering. Some people preferred staff to knock instead of ringing the bell and this was respected. Staff said, "I will always have a towel available to protect the person's dignity when I am giving them personal care"; "I know person centred care is important; this is done every day, that's a must, each person is different and I recognise the importance of equality and diversity" and "I will wash people and put a towel across to maintain their dignity and or put a long shirt on them".

People told us "They (staff) speak to you nicely and show respect"; "They maintain my independence and are discreet about this"; "Staff are polite, a nice bunch and always show me respect and dignity"; "They (staff) can be a lot of fun, I get enough help"; "Staff keep doors closed and help me in the bathroom" and "I am not embarrassed when they help me with personal care".

People's confidentiality was maintained. We saw people's records were kept in a secure locked room at all times. Staff told us they knew how important it was to maintain confidentiality of people and not to discuss any aspects of their care or personal details. Staff members said "Work stays at work" and "I don't talk about people in front of others or at home".

Good

Is the service responsive?

Our findings

People were assessed prior to moving to Swan Court and assessments were used to develop personalised care plans.

Care plans included detailed information relating to people's life histories, what and who was important to them, their likes and dislikes and there was a photograph of the person on the front of the file. Care plans included clear details of the level of support and how to deliver this support for care staff to follow. For example, people's goals, intervention to keep people safe, time of calls and what assistance people needed at each call. Details about risks associated with people's care were recorded and kept up to date, this included a falls risk assessment tool.

The provider had an electronic system to record people's care along with a hard copy of the details for staff to use as guidance. Staff told us and we saw any changes to people's needs or delivery of care was recorded in people's records. They said people can look at their care records when they wish and read them and make changes. One staff member said "All of the information we need to do our jobs is shared openly with staff and people. For example, new tenants assessments".

We saw systems were in place to review people's care including the associated risks. For example, manual handling, skin integrity, and medicine. We saw one person who had an occupational therapist review regarding their mobility. This person had problems with walking and this was regularly monitored by the staff and professionals. We saw options had been discussed and documented and the most appropriate form of assistance was in place. However, this person's mobility had deteriorated over the last few weeks and staff told us how they were arranging for a further review of this person's needs.

People told us they were happy with the level of care their received and that the provider was responsive to their needs. Comments included "I get the care I am supposed to have". One person told us how their relationship with their visitor was maintained. We saw the person had received communion and the visitor recorded their next visit on the person's calendar so that staff were aware of this visit. This visitor clearly had a strong bond with the person and they explained they had known the visitor for a number of years and it was important to keep this contact. Another person told us how they had their weekly farming magazine delivered to them, this was clearly important to them as they used to work on in this area. We met one person at Swan Court who told us they were very happy there. One staff member told us how they had improved this person's life. They said when the person first arrived they were quite shy and anxious. We saw this person had been out on a walk in the morning of our inspection with other people at Swan House. They obviously enjoyed this experience and the staff member told us how the person's mood had improved. They said "They are more outgoing now and less anxious, a real improvement". Other examples was where one staff member noticed a person was wearing inappropriate footwear on which may pose a risk to them when they joined people in the walking group. They told us how they persuaded the person to change their footwear the following week. Another person told us "Every Thursday I am invited to lunch in the lounge. It's a long way for me to walk, but they take me in the wheel chair".

When we were talking to people, one person said they would like all staff to wear name badges. We saw on the day all staff did display their name badge, but on some occasions this was not visible due to their clothing. We discussed this with the care team leader who assisted us on the day with our inspection. They told us they would look into this and possibly have bigger name badges for all staff so that people at Swan Court could clearly see these.

There were accurate, detailed records relating to health conditions and on-going treatment plans. For example, two people were diabetic and we saw their records were up to date with their blood glucose level checks.

There was a complaints policy and procedure in place. People said they would raise any concerns with one of the staff members or the care team leader and felt confident they would be listened to. There was a 'suggestion box' in the main corridor in Swan Court. People know about this and were able to raise concerns or make suggestions. We were told by the care team leader on the day of our inspection that this was regularly reviewed.

One person told us how they had complained about staff at night. They said "Night staff used to sit on the patio drinking tea and chatting. I reported it to the care team leader and she stopped it". Another person told us they had problems with their phone, they said staff had sorted this out for them quickly. Other comments from people included "I have no complaints" and "No grumbles at all". The visitor at the service told us they were also confident any concerns would be addressed immediately and were confident a quick response would be received.

Staff told us they knew how to handle any concerns or complaints. They said "Depending how people want to report it, I would try and address it, but if serious, I would report it and complete the forms etc" and "I know there are forms in the office, but I would see if I could deal with it by asking the person if they want to talk to me about it to see if it could be resolved. I would pass the details on though and mention it to the care team leader and alert staff through daily records".

Requires Improvement

Is the service well-led?

Our findings

The provider had quality audit systems in place, but these were not always effective. Monthly audits were to be carried out to ensure people's care needs had been reviewed and were up to date. However, these audits had not been undertaken since September 2016. We identified a number of areas of concern at the inspection which had not been identified through the providers auditing system.

We found reviews of people's care needs were inconsistent and not carried out regularly to ensure people received appropriate care. We saw two care files where people's risks had not been assessed since September 2016. We looked at both the electronic care records and paper records with the care team leader. We saw in one case the persons care plan had not been reviewed since July 2016. It was not clear why these reviews had not taken place. This meant people were at risk of receiving care which did not meet their needs.

Robust records were not maintained of accidents and incidents. When an incident occurred, staff were required to complete an incident form on the electronic system. We saw there had been two incidents in February 2017 where a person had managed to access Swan Court from Swan House. Records of these incidents had not been completed.

We found when incidents occurred which had effected a person, the person's care file had not been updated with the details. For example, the person who was affected by one of the incidents in February 2017, their care file had not been updated with the incident and there was no record to show this person's welfare had been checked following the incident.

We were told there had been a number of occasions when the care team leader for Swan Court had not been available in the last few months. We saw no oversight of this person's absence had been maintained and the effect on the quality of service delivery had not been maintained. For example, although staff told us they felt supported, they had not had formal and recorded supervision since October 2016. This meant a robust method was not in place to review the support of staff at Swan Court and to identify any needs or changes of staff needs.

Staff told us that they had not had regular meetings with the care team leader or the manager. We saw the last meeting took place on 11 October 2016. We were told these usually took place every six weeks. We saw individual needs were discussed at these meetings, for example medicine supplier changes. The notes did not demonstrate staff had the opportunity to raise or discuss any items in the meeting. Staff told us this did normally happen, but was not recorded. One staff member commented, "Yes it is time we had a meeting". This meant robust records were not maintained by the care team leader and the monitoring systems operated at Swan Court had not identified these areas through the audit process in place.

This is a breach of regulation of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked to look at one care staff member's recruitment and induction record. However, this was unavailable at the time of our inspection due to the absence of the usual care team leader and registered manager. We were therefore unable to confirm processes. However, we did contact the individual by email who confirmed details of their induction. We were later told by the registered manager that the file was in their office, but was not accessible on the day of our inspection.

The leadership and management from the care team leader who assisted us on the day of the inspection demonstrated an open approach and supporting culture that encouraged good care and team spirit. This care team leader came across from the sister home to support our inspection as the manager and care team leader of Swan Court were not available.

Staff comments on the workplace culture included; "It's ok working here, we have reasonable shifts and expectations of each other"; "I am happy to go over to Swan House and ask the manager or deputy if I have an issue"; "Service could not be better"; "Manager is approachable and can have an open conversation" and "It's well managed, but there is always room for improvement".

People's comments were "I am more than satisfied here in my case"; "Could not be better here"; "Communication is excellent" and "It is well led here, it's nice and we all get on well together". However, a few people at Swan Court did not know who the manager was. One person commented "Don't see them very often".

Staff told us they were well supported by the registered manager. They said, "Yes there is a good culture here, the manager does come around and has some days in the office"; "I feel listened to"; "The provider will check with us for feedback"; "The support is really great, always someone I can call" and "Always an open door policy here".

People's opinion on the service was sought by the provider. We saw annual surveys took place where people could provide feedback on the quality of the service. The last survey was December 2016. We saw the results of the survey and these were overall really positive. One comment made was 'At this moment in time I cannot think of improvements. I have been welcomed to Swan Court and receive friendly care and encouragement from all staff members. I am very pleased with the service I receive. I would like to mention the activities which are organised for us tenants. I enjoy the walks, memory groups and I am looking to join the friendship lunch meetings'. At our meeting with people, they told us "Yes I have had one survey since being here"; "I am asked about the service by staff"; "They ask me if everything is ok" and "Yes, they give me a form to fill in".

People told us of the community involvement that was available to them when living at Swan Court. They said they shared common interests with people who lived at Swan House. We saw and people told us of how they were encouraged to come and go as they pleased. For example, there was a walking group, the Winslow Big Society 'friendship' lunch, singing for pleasure group and shared facilities as one staff member brings though a sweet trolley to Swan Court from Swan House so that people can buy cakes and sweets of their choice.

Comments about the management of Swan Court from people, staff and visitors included, "Nothing needed differently here"; "It's my home upstairs, just how I want it"; "Best place I have lived in for years, no complaints"; "Could not be better off"; "If I was 90 years old and wanted to be looked after, I would come here"; "Very understanding, supportive and flexible"; "Everyone gets on with everyone else and cover each other's work, we are a team"; "It's run very well, ask for things and they get done"; "It's a nice place to come and work"; "I work well with all my colleagues" and "Love it here, people are lovely, staff are good and

communication is very good".

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. The provider was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.

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
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have a robust quality assurance system in place to effectively monitor the safety and quality of people's care.