Raphael Medical Centre Limited (The)

Swanborough House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection at Swanborough House on 11 April 2016. Swanborough House provides accommodation, care and rehabilitation for up to 31 people aged over 18 with acquired brain injury. On the day of our inspection there were 31 people living at Swanborough House. Some people stay for a structured time specific period of rehabilitation, but others are living more permanently at the service due to their specific needs in relation to their acquired brain injury. The service follows the Rudolph Steiner philosophy of holistic living. All catering, furnishings, decor and therapies offered follow this philosophy. The home is located in Brighton with access to local amenities, which include the local community centre. Public transport routes serve the area.

There was a manager in post, who had applied to become the registered manager. However at the time of our inspection, they were not registered with the CQC. 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.

During the inspection we saw that people were not routinely offered day to day choices around their care. They did not always have their independence promoted, and some had their dignity and privacy compromised. The manager told us, "I am aware there are some restrictions around choice. This is something I am looking at". We have identified this as an area of practice that needs improvement.

Medicines were managed and administered safely. People's medicines were stored safely and in line with legal regulations. People received their medicines on time. However, adequate guidance was not in place for the use of 'as required' medicines and care plans failed to demonstrate the steps required before administering the medicine. This therefore placed people at risk of receiving medicine that they did not require. We have identified this as an area of practice that needs improvement.

Staff had a good understanding of the Mental Capacity Act 2005 (MCA) and the provider was meeting the requirements of the Deprivation of Liberty Safeguards. People's consent to their care and treatment was assessed and staff had a good understanding of the Mental Capacity Act 2005 (MCA). However, we could not always see evidence of involvement with the individual or their representatives in how their decisions had been made. We have identified this as an area of practice that needs improvement.

We saw that regular staff meeting took place. Staff were encouraged to ask questions, discuss suggestions and address problems or concerns with management. However, we identified concerns in relation to feedback from staff being acted upon by the provider. We have identified this as an area of practice that needs improvement.

We found a breach 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 this report.

People were happy and relaxed with staff. They said they felt safe and there were sufficient staff to support them. One person told us, "I really do feel safe, yes". When staff were recruited, their employment history was checked and references obtained. Checks were also undertaken to ensure new staff were safe to work within the care sector. Staff were knowledgeable and trained in safeguarding adults and what action they should take if they suspected abuse was taking place.

Risks were thoroughly assessed and planned for. Accidents and incidents had been recorded and appropriate action had been taken. Risks associated with the environment and equipment had been identified and managed. Emergency procedures were in place in the event of fire and people knew what to do, as did the staff.

People were encouraged and supported to eat and drink well. There was a varied daily choice of meals and people were able to give feedback and have choice in what they ate and drank. One person told us, "The food is very good here. We get a good variety". Special dietary requirements were met, and people's weight was monitored, with their permission. Health care was accessible for people and appointments were made for regular check-ups as needed.

Staff had received essential training and there were opportunities for additional training specific to the needs of the service, including the use of buccal midazolam to stop seizures and the care of people with an acquired brain injury (ABI). Staff had received supervision meetings with their manager, and formal personal development plans, such as annual appraisals were in place. One member of staff told us, "We have had specific training for working here, such as catheter care and how to manage challenging behaviour".

Care plans provided detailed information about people and were personalised to reflect that person's rehabilitation programme. The care plans were reviewed regularly to reflect the person's change in need and the progress that they had made. People and their families were involved as part of these reviews. There was a range of interesting and social activities on offer at the home, which people could participate in if they chose.

The management team promoted a positive culture where person centred practice was promoted and people's rehabilitation was planned and monitored. There was a motivated and committed team of staff. One member of staff said "We discuss people's needs with colleagues and what has happened during the day. We are an international team and we are a good team. I really enjoy working with my colleagues". There was a range of audit tools and processes in place to monitor the care and support that was provided. This ensured the management team were assessing the quality of the care and support provided.

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 consistently safe.

Medicines were managed, stored and administered safely, however, guidance was not consistently in place to ensure the appropriate use of 'as required' (PRN) medicines.

People were supported by staff that recognised the potential signs of abuse and knew what action to take. There were enough staff and safe recruitment practices were followed.

People's risks were assessed and managed appropriately. There were comprehensive risk assessments in place and staff knew how to support people.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's consent to their care and treatment was assessed and staff had a good understanding of the Mental Capacity Act 2005 (MCA). However, we could not always see evidence of involvement with the individual or their representatives in how their decisions had been made.

Staff had access to a wide range of training and new staff completed a comprehensive induction programme.

People could choose what they wanted to eat and had sufficient amounts to maintain a balanced diet. People were supported to access a range of healthcare professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Care practices did not always respect people's privacy and dignity and people were not consistently treated with respect.

People were restricted in relation to certain choices and their independence was not fully promoted.

Staff knew people well and friendly, caring relationships had been developed. People felt well cared for.

Is the service responsive?

Good

The service was responsive.

Care records accurately recorded people's likes, dislikes and preferences. Staff had information that enabled them to provide support in line with people's wishes.

People were supported to take part in activities within and away from the service. People's interests were used as a way of motivating people with their rehabilitation goals.

There was a system in place to manage complaints and comments. People and relatives felt able to make a complaint and were confident that any complaints would be listened to and acted on.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Staff were encouraged to feedback on the quality of the service, however this feedback was not routinely acted upon.

There were systems in place to monitor the quality of the service, highlight any shortfalls and identify actions necessary for improvement.

The manager was fully involved in the day to day running of the home and had created a culture where there was open communication and a positive outlook. People were asked for their views about the service and included in its development.

Swanborough House

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 11 April 2016 and was unannounced. Two inspectors, a specialist adviser with an understanding of the needs of people with an acquired brain injury and an expert by experience undertook this inspection. 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 our inspection we reviewed the information we held about the service. We considered information which had been shared with us by the local authority and clinical commissioning group, and looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. The provider had 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 observed care in the communal areas of the service. We spoke with people and staff, and saw how people were supported during their lunch. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. We spent time looking at records, including seven people's care records, six staff files and other records relating to the management of the service, such as training records, food and fluid recording charts, accident/incident recording and audit documentation.

During our inspection, we spoke with eight people living at the service, five care staff, the manager, two administration staff, the occupational therapist, two maintenance staff and two ancillary staff, including the chef. We also 'pathway tracked' people living at the home. This is when we followed the care and support a person's receives and obtained their views. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

The last inspection took place on 7 February 2014, where no concerns were identified.

Requires Improvement

Is the service safe?

Our findings

People said they felt safe and staff made them feel comfortable. One person told us, "Yes, I feel safe here". Another person told us, "I really do feel safe, yes". Everybody we spoke with said that they had no concern around safety. However, despite the positive feedback, we saw areas of practice that need improvement.

We looked at the management of medicines. Care staff were trained in the administration of medicines. People told us they received their medicines safely. One person said "I get my medication after dinner and before bed time". Nobody we spoke with expressed any concerns around their medicines.

We observed a member of staff administering medicines in the medicine room. They administered medicines to people in a respectful way and stayed with them until they had taken them safely. Medicines were stored appropriately and securely and in line with legal requirements. A member of staff described how they completed the medication administration records (MAR). We saw these were accurate. We checked that medicines were ordered appropriately and medicines which were out of date or no longer needed were disposed of safely. Routine auditing of medicine procedures had taken place, including checks on accurately recording administered medicines as well as temperature checks and cleaning of the medicines fridge. The service had a medication policy and procedures to inform their practice.

However, there was shortfalls in the management of 'as required' (PRN) medicines. PRN medicines can be prescribed for people to manage levels of anxiety, behaviour that challenges or periods of anxiousness. PRN medicine should only be offered when symptoms are exhibited. Clear guidance and risk assessments must be available on when PRN medicine should be administered and the steps to take before administering it. PRN care plans were in place for the management of PRN medicines and the steps to take before administering it, but they did not contain enough information to guide staff on what to administer and when. Some people were prescribed variable doses of PRN medication, details of which were located in their care plans. However, the care plans stated that staff were to administer the dose depending on the severity of the behaviour. Documentation failed to reflect the steps taken before administering the medicine, the person's mood, presentation or how their behaviour presented. Records also failed to reflect the effectiveness of the medicine and to make sure it was working for the purpose it was prescribed for. A member of staff told us that in such a situation they would ask the person how they felt, and if they were unable to answer they would decide the amount and type of PRN medication to give them by their body language. This lack of clear guidance meant people could be at risk of receiving PRN medicine incorrectly or inappropriately. We have identified this as an area of practice that needs improvement.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. Health and safety checks had been undertaken to ensure safe management of utilities, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. There was a business continuity plan. This instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property.

There were a number of policies to ensure staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people from abuse. Records confirmed staff had received safeguarding training as part of their essential training at induction and that this was refreshed regularly. Staff described different types of abuse and what action they would take if they suspected abuse had taken place. One member of staff told us, "I have done safeguarding training, I would raise any concerns about abuse".

There were systems to identify risks and protect people from harm. Detailed risk assessments were carried out with people by staff and they then developed guidelines for the care and treatment of each person based on these risk assessments and their individual needs. These included risk assessments in areas such as behaviours of concern, nutrition, mobility, accessing the community, using kitchen appliances. The guidelines were used by staff to make sure they provided the people they supported, with the appropriate care. The guidelines were updated by the staff to take account of changes in people's wellbeing and were valued as informative by staff. One member of staff told us "I always read the risk assessments and care plans, they have all the information in them that we need. We also discuss any risks with colleagues". The care records we checked confirmed that risk assessments were detailed and up to date. We also saw safe care practices taking place, such as staff supporting people to mobilise around the service.

We spoke with staff and the manager and staff about the need to balance minimising risk for people and ensuring they were enabled to try new experiences. The manager said, "We assess for positive risk taking for example the risk for residents to access the community. Some may have communication difficulties, so we discuss safety and build their confidence and trust to be able to go out and come back safely and communicate". A member of staff added, "We encourage people to take risks, we are providing a rehabilitation service, so they need to develop their skills".

A multidisciplinary team of staff provided support to ongoing residential placements and the rehabilitation programme, including assessment, ongoing rehabilitation and support to return to the community. Staffing levels were assessed daily, or when the needs of people changed, to ensure people's safety. The manager told us, "We have enough staff, plus we have volunteers and bank staff when needed". The manager gave us an example of how they had introduced extra staff into the service in order to provide one to one care for a person. We were told agency staff were rarely used and existing staff would be contacted to cover shifts in circumstances such as sickness and annual leave. Feedback from people and staff indicated they felt the service had enough staff and our own observations supported this. One person told us, "Yes, there are always staff about". A member of staff said, "It's ok for staff here at the moment. It is sometimes short if someone rings in sick, but we get cover. We get everything done we need to do, we don't neglect anybody". Our own observations supported this. Staff were on hand at all times to assist people when required, and staff appeared calm and unhurried in their duties.

Staff had been recruited through an effective recruitment process that ensured they were safe to work with people. Appropriate checks had been completed prior to staff starting work which included checks through the Disclosure and Barring Service (DBS). These checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. The provider had obtained proof of identity, employment references and employment histories.

Requires Improvement

Is the service effective?

Our findings

People told us they received effective care and their individual needs were met. One person told us, "They look after us, we get fed and I can talk to the staff here". Another person said, "The staff are good, they do what you want". A further person added, "The staff are nice, they all know what to do". However, despite the positive feedback, we saw areas of practice that need improvement.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. Staff told us they explained the person's care to them and gained consent before carrying out care. Staff had knowledge of the principles of the MCA and gave us examples of how they would follow appropriate procedures in practice. One member of staff told us, "I have had training on the MCA, we always seek consent and ask first". The manager and staff understood the principles of DoLS and how to keep people safe from being restricted unlawfully. They also knew how to make an application for consideration to deprive a person of their liberty, and we saw appropriate paperwork that supported this.

We saw that assessments of mental capacity were in place in people's care plans and where a best interests decision had been made this was recorded. We could see that assessments and decisions had been signed as agreed by staff. However, in some people's care plans we could not see any evidence of involvement with the individual or their family, friends, carers or any IMCA (Independent Mental Capacity Advocate) in how the decisions had been made. We raised this with a member of staff, who told us that people were involved in the assessments, but they were not able to provide evidence to support this. The MCA is designed to protect people who lack capacity to make a specific decision. The philosophy of the legislation is to maximise people's ability to make their own decisions and place them at the heart of the decision making. The person should be encouraged and helped to join in making the decision wherever and to whatever extent that is possible. It is therefore vitally important that care, treatment and support records show that people are properly involved in making decisions about their lives, and that it can be confirmed that, where appropriate, relevant supporters have been consulted. We have identified this as an area of practice that needs improvement.

Staff had received training in looking after people, for example in safeguarding, food hygiene, fire evacuation, health and safety, equality and diversity. Staff completed an induction when they started working at the service and 'shadowed' experienced members of staff until they were assessed as competent to work unsupervised. They also received training specific to peoples' needs, for example around the use of buccal midazolam to stop seizures and percutaneous endoscopic gastrostomy (PEG) feeding. This is an

endoscopic medical procedure in which a tube is passed into a person's stomach through the abdominal wall, to provide a means of feeding when oral intake is not adequate. The manager told us, "Staff receive specific training, for example how to provide key support for people with and acquired brain injury (ABI). We used a trainer who had an ABI to train staff, they also spent time with residents to give them a positive outlook". Staff told us that training was encouraged and was of good quality. Staff also told us they were able to complete further training specific to the needs of their role, one member of staff said, "We have had specific training for working here, such as catheter care and how to manage challenging behaviour". Our own observations supported this. Staff were seen to be confident and competent and demonstrated they had the appropriate skills in relation to the care they delivered.

Staff received support and professional development to assist them to develop in their roles. Feedback from staff and the manager confirmed that formal systems of staff development including one to one and group supervision meetings and appraisals were in place. Supervision is a system that ensures staff have the necessary support and opportunity to discuss any issues or concerns they may have. One member of staff told us, "We get supervision. It is definitely useful, as there is always some small thing to learn". Another added, "Supervision is helpful".

People had an initial nutritional assessment completed on admission, and their dietary needs and preferences were recorded. This was to obtain information around any special diets that may be required, and to establish preferences around food. There was a varied menu and people were offered alternative food choices depending on their preference. The menu showed that fresh vegetables were used daily, as well as fresh fish and fresh meats. Everybody we asked was aware of the menu choices available.

We observed lunch. People were considerately supported to move to the dining area or could choose to eat in their bedroom. The lunch tables were quite bare, and there were no tablecloths, placemats or table decorations. We were told this was in keeping with the environment and ethos of the service, and nobody we spoke with expressed any concern around dining experience. Staff were available if people required support or wanted extra food or drinks. The lunch was honey roasted lamb, potatoes and salad. The food appeared appetising and the chef had previously told us that all food served was organic. All the time staff were checking that people liked their food and offered alternatives if they wished. For example, one person stated they did not want the lamb and had a jacket potato instead, which was made for them. People were complimentary about the meals served. One person told us, "The food is very good here. We get a good variety". Another said, "I can eat anything they give me". A further person added, "The food is nice. It's lamb today and pasta later. They give me a jacket potato or other things if I want, because I don't like pasta".

People's weight was regularly monitored, with their permission. Some people were provided with a specialist diet to support them to manage health conditions, or cultural requirements. We saw that details of people's special dietary requirements, allergies and food preferences were recorded to ensure that the cook was fully aware of people's needs and choices when preparing meals. Where required, we saw that advice was sought from the GP, dietician and speech and language therapist (SALT). The manager told us, "We have SALT involvement all the time around swallowing and Dysphagia (Dysphagia is the medical term for swallowing difficulties). Specialist diets are being followed and people's dietary needs are being met".

Swanborough House offers ongoing residential care and a rehabilitation service. Due to the nature of people's treatment several people we spoke with had to attend external health appointments. People had no concerns that if they became ill they knew they would be attended to. One person told us how if they felt unwell, staff always acted upon their concerns and sought advice from their GP. Another person said, "Generally there is a person here, she will organise GP visits". A further person added, "They take us to the GP and to hospital". People's health and wellbeing was monitored on a day to day basis. Where required,

people were supported to access routine medical support, for example, from an optician to check their eyesight. One member of staff told us, "We know when people aren't well and we support them to go to appointments, like the dentist". In addition, people had input into their care from healthcare professionals such as doctors, occupational therapists, speech and language therapists and dieticians whenever necessary.

Requires Improvement

Is the service caring?

Our findings

People told us they were supported with kindness and compassion, and that caring relationships had developed with staff. Everyone we spoke with thought they were well cared for. One person told us, "I trust the staff". Another person told us, "The staff are very nice". However, despite the positive feedback, we saw areas of practice that need improvement.

During the inspection we saw that people were not routinely offered day to day choices around their care. They did not always have their independence promoted, and some had their dignity and privacy compromised.

We observed people being given a variety of choices of what they would like to do and people were empowered to make some of their own decisions. However, we saw that people spent significant periods of the day in the lounges of the service. There were signs in each lounge stating that 'no eating or drinking was allowed in the lounge'.

At 11:24am there were 13 people sitting in the ground floor lounge. People were seen to be sleeping, reading, listening to the music or talking with staff and each other. At 11:31am two members of staff entered and addressed the room. One member of staff said, "Do you want tea? It is served next door. Follow me please, it is tea time next door". The other member of staff said, "Can you follow me please, it is tea time, it is time to go next door". Two people were woken from their sleep and made their way to the dining room, and it was clear that some people had mobility issues and required support to walk out to the corridor and to the next room. Staff were polite to people and if people wished to remain in the lounge this was respected. However, no choice was given to people to have their drink and snack in the lounge where they were relaxing. Additionally, the people who chose not to move did not receive a drink or snack. After the 'tea time' was finished, we saw people supported again to move back to the lounge or other parts of the service. This same procedure was repeated at lunchtime, with people not being given the choice to remain in the lounge to enjoy their lunch should they wish. We asked people if they would like to eat or drink in the lounge, rather than move to the dining room. One person told us, "We can't eat in the lounge and we have a TV lounge upstairs that we can't eat in either. It's not allowed". Another said, "We're not allowed. We can't do that. It'd cause arguments, because everyone would want to do it". We raised this lack of choice around where people could eat and drink with staff and the manager. One member of staff told us, "There is no food or drinks allowed in the lounges. The residents can have them in their rooms or the dining room or kitchens". Another added, "I don't know why they are not allowed to eat and drink in the lounges, that's just the way it always has been". The manager said, "I am aware there are some restrictions around choice. This is something I am looking at".

We saw that visitors were welcomed to the service. However, a sign was displayed on the front door that stated 'no visitors were permitted after 6:00pm'. We raised this restriction with staff and the manager. One member of staff said, "Our residents like to have a rest after dinner". The manager told us, "We put that sign up as sometimes visitors would just show up. If somebody wanted to visit after 6:00pm, if they let us know we would let them". Additionally, we saw that choice was not always given to people in relation to where

they would like to take their medication. A member of staff told us they would occasionally administer medication to people in other areas of the service, however people were routinely were called to the medicines room for their medication. We saw that this was the case. People were told to go to the medicines room when their medication was ready and were not given the choice to have their medication where they were sitting or in their rooms.

A fundamental part of providing people with dignity in care is ensuring that as far as possible, they have choice and control in what they do and where they would like to spend their time. When a person enters a residential care setting, this service effectively becomes their 'home'. Unless a risk was too great, people within their own home would not be restricted in where they could enjoy a drink or meal and take their medication. Additionally, it would be deemed reasonable for somebody to accept a visitor into their home after 6:00pm without prior arrangement. Having designated areas and times in which to eat, drink, take medication and receive visitors is not person centred and does not promote choice, or respect people's independence and dignity.

An important aspect of the service was to provide rehabilitation for adults with acquired brain injury who had the potential to increase their social participation and their independence. As a result people were encouraged to be independent by undertaking a rehabilitation programme including both individual and group sessions, specifically designed to meet their needs. The manager and staff gave us examples of how they promoted people independence. One member of staff told us "We support the residents with their living skills. We look to rehabilitate and promote independence. I help one resident to use their electric toothbrush and encourage them to use the exercise bike". Another said "I ask them what they want to wear and how they want to dress. I encourage them to do it themselves". However, despite seeing positive examples, we identified some areas where people's independence was not being fully supported. For example, in the dining room at lunchtime, we saw several people struggle to eat their meal independently. One person's food continually fell off their plate as they could not pick it up with their spoon. Adapted cutlery and plate guards were used by some people, however they were not routinely made available for people whom it may have assisted them to eat independently.

Additionally, in one part of the service, there were two independent flats. These flats had a shared kitchen, and there is also an occupational therapy kitchen in the service. These kitchens are designed for people to practice independent living, improve their skills and be assessed on their progress. We looked at both kitchens and could not see any evidence of adapted equipment to assist people in activities of daily living and their rehabilitation. Work surfaces in the kitchen could not be adjusted in height to cater for standing or wheelchair dependent people. The work surfaces did not allow for sliding items from the cooker hob to a work surface, thus reducing the risk of spillages. Additionally in the kitchen of the independent flats, the washing machine door handle was broken and it could not be used. As part of a rehabilitation service, it would be expected that specialist equipment would be in place, so that home living can be replicated and supported. Both kitchens appeared dated and it was not possible to see how they were used to promote rehabilitation and independent living.

We observed some care practices which upheld people's privacy and dignity. For example, care staff always knocked before entering someone's bedroom. Some of the feedback we received from people was very positive around the care staff and comments included, "They look after us" and "I feel well looked after". Staff discussed people's care needs in a respectful and compassionate way and they were able to describe how they maintained people's privacy and dignity. For example one staff member told us, "We always knock before going in rooms and respect the residents, and always close the curtains". However, we found the principles of privacy and dignity were not embedded into every day care practice. For example, at 11:26am in the ground floor lounge a person asked a member of staff, "Can I have my tablets?" The member of staff

replied, "No, you can have them after your lunch" and walked away. The member of staff did not ask what tablets the person was referring to, or check to see whether the person was in pain or agitated. Nor did they explain to the person why they needed to wait until after the lunch service.

Additionally at 10:18am a person was sitting in their wheelchair in the main corridor outside the medicines room on the ground floor. We saw a member of staff administer five separate injections into the persons PEG tube. Percutaneous endoscopic gastrostomy (PEG) feeding is an endoscopic medical procedure in which a tube is passed into a person's stomach through the abdominal wall, to provide a means of feeding when oral intake is not adequate. The person involved appeared self-conscious, as this procedure was taking place in full view in the ground floor corridor, where members of staff and other people were walking by. No measures were taken to protect this person's privacy and dignity and at no point did any member of staff intervene to challenge this practice. We raised this incident with the manager, who told us that this practice would not be acceptable. They stated that it must have been an isolated incident, and they would discuss it with the staff involved. We have raised this incident with the Local Safeguarding Authority.

Dignity and respect are key principles of the Human Rights Act. When a person's dignity is compromised and no respect is afforded them, it is an infringement of their human rights.

The above evidence demonstrated that people's care and treatment was not delivered in a way that supported their independence, ensured their dignity and treated them with respect at all times. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have identified this as an area of practice that needs improvement.

Despite the concerns identified above, it was clear that staff demonstrated a commitment to providing compassionate care. Interactions between people and staff were positive. There was sociable conversation taking place and we observed staff being caring, attentive and responsive, with good eye contact and appropriate communication. Staff appeared to enjoy delivering care to people. From talking with staff, it was clear that they knew people well and had a good understanding of how to support them. Staff gave us examples of people's individual personalities and character traits, whether they liked to join in activities and their preferences in respect of food. Most staff also knew about peoples' families and some of their interests. People looked comfortable and they were supported to maintain their personal and physical appearance. For example, people were dressed in their own individual styles and appeared well groomed.

Good

Is the service responsive?

Our findings

We saw that the care and support people received care that was responsive to their needs and was designed to meet their individual goals. People told us that staff knew them and their particular likes and dislikes, and they were supported to take part in activities in and out of the service. One person told us "I go to a restaurant in Brighton and my Mum and daughter visit me". Another told us, "I've just been to the shops and had a coke".

People's care plans reflected their interests and preferences and these were used as a focus for supporting people with their daily care and rehabilitation. We saw that people's needs were assessed and plans of care were developed to meet those needs, in a structured and consistent manner. Care plans contained personal information, which recorded details about people and their lives. This information had been drawn together by the person, their family and staff. Each section of the care plan was relevant to the person and their needs. Areas covered included; mobility, nutrition, continence and personal care. Information was also clearly documented regarding people's healthcare needs and the support required to meet those needs. Care plans contained detailed information on the person's likes, dislikes and daily routine with clear guidance for staff on how best to support that individual. The manager told us that staff ensured that they read peoples care plans in order to know more about them. We spoke with staff who confirmed this was the case. One member of staff told us, "I read the care plans and risk assessments, they have what we need in them".

As part of people's rehabilitation, they had plans in place to set goals and achievements. The manager told us that goal setting meetings took place every three months. We saw that this was the case, and they included the person, their key worker and a therapist. The manager gave us an example of a person at the service whose long term goal was to return home. We saw that this person had previously had issues with their memory and had no confidence in accessing the community. Through goal setting, support and encouragement, this person had gained independence and daily living skills. They now accessed the shops independently and had been supported to have accompanied sessions at their home, where their daily living skill were assessed. The manager told us that they had made excellent progress and now the person was having unaccompanied sessions at home. The manager had also made arrangements with the GP around medication, so that this person did not need to rush back to Swanborough House in the evening. The service also invited previous residents back, to talk with people about moving on from the service and giving positive examples.

Staff gave us further examples of goals being set for people. One member of staff told us, "One resident wanted to lose some weight, so they now do 15 – 20 minutes exercise in the morning which we prompt them to do". Another said, "I go clothes shopping with one resident. They like red clothes. I check the sizes are right and support them to shop". The added, "One resident wanted to get a bit fitter, so we have encouraged them to exercise. When we go to the garden centre, we get off the bus three stops early and walk back". Another member of staff told us, "[The person I key work] has his own timetable with goals to achieve. On Thursday's he goes out. He goes to the bank. On Friday's he likes cooking. So, I take him to the supermarket". Staff also told us they knew people well and had a good understanding of their family history,

individual personality, interests and preferences, which enabled them to engage effectively and provide individualised care. Staff gave us examples of people's individual personalities and character traits that were reflected in people's care plans. One member of staff told us, "We have one resident who always wears a suit and likes to look nice and go to the theatre". We saw that this person was well dressed and there were pictures displayed in the service of their theatre trips.

Activity sessions were tailored to people's individual needs. We noted that they included sessions to help people improve their activities of daily living, health and fitness, communication and social skills, the understanding of their brain injury and the improved management of any associated behavioural and psychological consequences. Activities took place in the lounge and there were also specific rooms where activities such as music therapy took place. The service also had a pool table and darts board.

We observed individual therapies and group activities. The service had a topic of the week, which was 'What Moves – Trains' and we saw staff facilitating a group discussion on this subject. There was also choir session and a discussion around current affairs. We saw people drawing and playing board games. A member of staff said to somebody, "That's a good picture", "Thank you" the person responded and they smiled and shook hands. A member of staff told, "The residents like the activities. The book club keeps people's reading skills going". The manager added, "We have a lot of activities. There is also a local gardening group that residents help out with and plant trees, they also go for a pub lunch and there is an annual holiday for residents to Kent".

The service also supported people to maintain their hobbies and interests, for example one person was interested in ventriloquism and they had puppets on the table of their wheelchair for them to use. We saw that this person had also been supported to visit a circus. Another person enjoyed going out to eat Italian food, they told us, "I have pizza and a coke". We saw that one person had an interest in motorbikes, and the manager told us, "He likes to attend old care events and we look at motorbike information on the I-pad. Another person has visited the circus and there are theatre outings to Brighton".

People were given the opportunity observe their faith and to attend the place of worship of their choice. The manager told us, "We have a priest who comes in and one of the residents is a Muslim, who we support to go to the mosque". We saw that religious services were made available for people at the service.

People knew how to make a complaint and told us that they would be comfortable to do so if necessary. They were also confident that any issues raised would be addressed by the manager. One person told us, "I talk to the manager. Something I don't like, I tell them. I'm alright". Complaints made were recorded and addressed in line with the policy with a detailed response. The procedure for raising and investigating complaints was available for people.

Requires Improvement

Is the service well-led?

Our findings

People and staff spoke highly of the manager and felt the service was well-led. Staff commented they felt supported and could approach the manager with any concerns or questions. One person told us, "The manager is nice, she asks me if I'm happy". Another person said, "I don't have any complaints". A member of staff added, "I can approach the manager any time, I like her". However, despite the positive feedback, we saw areas of practice that need improvement.

We saw that regular staff meetings took place. Staff were encouraged to ask questions, discuss suggestions and address problems or concerns with management. However, we identified concerns in relation to feedback from staff being acted upon by the provider. During our inspection, we saw that several chairs in the lounge were ripped and had plastic bags on them to cover the damage. We looked at staff meeting minutes and saw that staff had raised the issue of the damaged chairs with the provider at a staff meeting on 16 February 2016. The provider stated in the minutes that they would 'look into it'. The same issue was raised in a staff meeting again on 29 March 2016. The provider once again stated that 'they were still looking into it'. At our inspection on 11 April 2016 the chairs still hadn't been replace or fixed. Ripped chairs pose a possible infection control risk, and it is also undignified for people to sit on damaged furniture. As part of their governance, providers must seek and act on feedback from people using the service, those acting on their behalf, staff and other stakeholders, so that they can continually evaluate the service and drive improvement. All feedback should be listened to, recorded and responded to as appropriate. It should be analysed and used to drive improvements to the quality and safety of services and the experience of engaging with the provider. Requests by staff to replace damaged chairs would be considered a reasonable request. Providers must ensure that improvements should be made without delay once they are identified, and the provider should have systems in place to communicate how feedback has led to improvements. We have identified this as an area of practice that needs improvement.

We discussed the culture and ethos of the service with the manager and staff. They told us, "We support the residents and help them to achieve their goals. We also give recognition to staff. We have employee of the month to recognise achievement and team building events. Building relationships in the team improves the care at Swanborough House". A member of staff said, "I think we provide good care. The residents like the food and the activities". Another added, "The residents like it here, they are very happy and so are their relatives". Staff said they felt well supported within their roles and described an 'open door' management approach. One said, "I like it here. I have been very supported since I started here. Supported with training, but also supported with my language". Another said, "I do like it here, I've been here a long time. The manager is very supportive, I can always go to her".

Management was visible within the service and the manager took a hands on approach. The manager told us, "I like going out on the floor and being seen". The service had a strong emphasis on team work and communication sharing. Handover between shifts was thorough and staff had time to discuss matters relating to the previous shift. Staff commented that they all worked together and approached concerns as a team. One member of staff said, "We discuss people's needs with colleagues and what has happened during the day. We are an international team and we are a good team. I really enjoy working with my colleagues".

Another member of staff said, "We support each other and discuss how people have been, so that we can stop things developing".

Accidents and incidents were reported, monitored and patterns were analysed, so appropriate measures could be put in place when needed. Staff knew about whistleblowing and said they would have no hesitation in reporting any concerns they had. They reported that managers would support them to do this in line with the provider's policy. We were told that whistleblowers were protected and viewed in a positive rather than negative light, and staff were willing to disclose concerns about poor practice. The consequence of promoting a culture of openness and honesty provides better protection for people using health and social care services.

The provider undertook quality assurance audits to ensure a good level of quality was maintained. We saw audit activity which included medication and care planning. The results of which were analysed in order to determine trends and introduce preventative measures. Satisfaction surveys were carried out, providing the registered manager with a mechanism for monitoring people's satisfaction with the service provided. Feedback from the surveys was on the whole positive and further surveys had been sent to relatives, staff and professionals. We were told that people gave feedback about staff and the service, and that residents' meetings also took place. We saw minutes of meetings which supported this.

The manager informed us that they were supported by the provider and attended regular management meetings to discuss areas of improvement for the service, review any new legislation and to discuss good practice guidelines within the sector. Up to date sector specific information was also made available for staff, including guidance around moving and handling and updates on training available. We saw that the service also liaised regularly with the Local Authority and Clinical Commissioning Group (CCG) in order to share information and learning around local issues.

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	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's care and treatment was not delivered in a way that supported their independence, ensured their dignity and treated them with respect at all times.