Ambient Support Limited

Swan House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Swan House is a residential care home providing accommodation and personal care to 16 people aged 65 and over, at the time of the inspection. The service can support up to 32 people.

Swan House accommodates 32 people across two units, each of which have a small kitchen area, dining room, sitting room and communal bathrooms. The bedrooms have en-suite shower facilities. One of the units provides care to people living with dementia.

People's experience of using this service and what we found
We had limited feedback from people about their care. We observed some people had positive relationships with staff and they were relaxed and happy in staff company. Some people told us they wanted to be at home and others gave us mixed feedback on the meals and activities provided. A person commented, "The activities available don't interest me" and "The food varies, the meatballs today were better than I have had before."

A relative told us they were extremely happy with their family member's care. They felt confident that their family member was safe and well cared for. They commented "[Family member's name] is happy, safe and comfortable. I feel the staff fully understand their needs and can calm and reassure them."

A health professional commented "I have always found the staff at Swan house to be caring, willing to go the extra mile and proactive, in the course of my involvement with the home."

We found safe care and treatment was not provided. People were not safeguarded from abuse and risks to them, including infection control risks which were not identified and managed. Safe medicine practices were not promoted. Accident and incidents were not effectivley managed and there was no evidence of learning from these incidents to prevent reoccurrence.

Safe recruitment practices were not followed, and staff were not always supervised and trained in line with the provider's policy.

The records and systems in the service did not support best practice on the application of the Mental Capacity Act 2005 to ensure people were supported to have maximum choice and control of their lives in the least restrictive way possible and in their best interests.

The service was not effectively managed and monitored. The registered manager did not oversee the delegation of tasks and where actions were agreed they were not followed up and addressed. They failed to make the required improvements to the service and had not identified where other improvements were required. Staff felt well supported by the senior care team but less so by the management of the service.

The registered manager failed to make the required notifications to us and did not understand their responsibility under the duty of candour regulation. Some records relating to the running of the service were unavailable, contradictory, incomplete and not suitably maintained.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection and update The last rating for this service was requires improvement (published 12 December 2019) and there were multiple breaches of regulations. The service has been rated requires improvement for the past three consecutive inspections. At this inspection the rating has deteriorated further.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had been made and the provider was in continued breach of regulations.

Why we inspected
We undertook this targeted inspection to check whether the Warning Notice we previously served in relation to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met.

We inspected and found there was concern with the management of risks, medicine practices, safeguarding people, consent to care, recruitment of staff, records and good governance so we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led.

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

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Swan House on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified continued breaches and new breaches of regulations at this inspection in relation to safe care and treatment, safeguarding from abuse, recruitment practices, consent to care, good governance, duty of candour and in informing the Commission of incidents they are required to.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will

return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe, and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Swan House

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by two inspectors.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The inspection was announced on the day. This was to establish if the service had any suspected or confirmed COVID-19 infections which might prevent our access to areas of the home.

What we did before the inspection
We reviewed information we had received about the service since the last inspection and sought feedback from local authority professionals who work with the service. We requested information, policies and records from the service. This enabled us to access records remotely and plan what we needed to focus on at the inspection site visit.

We reviewed nine service user care plans, risk assessments and medicine records. We reviewed a range of other records including staff rotas, training records and staff meeting minutes.

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

During the inspection
We spoke with four people using the service and ten members of staff, including the registered manager, interim operations manager, activities coordinator and home chef.

We reviewed infection control and medicines practices, observed the environment and looked at records on the electronic care plan system. We also examined a variety of other records including audits and cleaning schedules to support the information we had received prior to the inspection.

After the inspection
We continued to review records shared electronically and continued to seek clarification from the provider to validate evidence found. We looked at three staff recruitment and supervision files, action plan, health and safety records, and revised care plans. We had a telephone call with the registered manager, deputy manager and interim operations manager to share our findings and seek feedback about their plans to implement improvements at the service. We sougnt feedback from relatives and professionals. We received written feedback from one relaitve and two professionals.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection risks to people were not managed, safe medicine practices were not promoted, poor practices were not addressed, and a safe environment was not promoted. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A warning notice was served with a date of compliance of the 1 December 2019.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12 and had failed to comply with the warning notice.

Assessing risk, safety monitoring and management

- Risks to people were not identified and managed. The service supported a person with a diagnosis of diabetes. Some staff we spoke with were unable to identify the risks associated with this medical condition, and no risk assessment was in place to provide guidance to staff about potential risks.
- Some people living at the service were at risk of falls. Records showed a person had experienced eight falls between 15 September 2020 and 25 October 2020. A falls risk assessment updated on the 25 October 2020 indicated a sensor mat had been considered and a falls referral would be requested from the GP. At the time of our inspection there was no sensor mat in place and staff were unable to evidence or confirm the GP referral had been made. Staff confirmed they had discussed the situation with the registered manager. The registered manager was unable to explain why a sensor mat had not been provided and stated, "It is a case of forgetting." Staff informed us the frequency of falls had reduced however the risk of falls had not been mitigated and daily records indicated a further fall had occurred on 9 November 2020.
- The service supported a person who exhibited self-neglecting behaviours, with a reluctance to accept support with personal care. Records viewed did not evidence personal care was encouraged daily; over a period of 56 days, there were 15 entries to document where personal care had been offered, accepted or declined. The records indicated there were concerns about the condition of the person's skin, however no medical treatment had been sought. The service had requested advice from a mental health professional but had not documented a risk assessment to guide staff on how to support this person when they declined care.
- Some people were at risk of choking. A person's care plan indicated their swallowing ability had reduced and they required a fork mashed diet. However, there was no risk assessment in place in relation to the risk of choking and staff we spoke with on the unit were unaware of the potential choking risk.
- The service supported people who presented with behaviours that challenged. Risk assessments were not in place to support staff to manage risks and staff worked without guidance on how to deescalate situations safely and consistently. One person's care plan raised concerns regarding their behaviour towards the home's environment, which presented safety risks. There was no risk assessment in place to identify the

potential risks to the individual, staff or other people using the service.
● A recent health and safety audit had been carried out. The service had failed to follow up some of the identified actions, which included the need to close the cleaning cupboard door. During our inspection we observed the door to this store of cleaning products propped open. This was addressed and made secure during the inspection.
● The legionella report completed 31 October 2019 assessed the service as Medium-High risk and recommended several immediate actions to ensure safe water management. This had not been followed up in a timely manner to determine if actions were completed by the landlord of the building.
● We identified concerns regarding food hygiene in relation to labelling and storage. An open milk container and a carton of juice without open-date labelling was in use and a milk container had been left out on the counter. These were brought to the interim operations manager's attention and acted on.

Learning lessons when things go wrong
● The service had no system in place to evidence how they learnt lessons when things went wrong. Staff told us they regularly discussed issues and were always learning from incidents but had not recorded those discussions. We saw in team meetings minutes issues around poor practice were discussed but there was no follow up, actions or ongoing monitoring to prevent reoccurrence. Following feedback with the inspector prior to the inspection, lessons learnt folder had been introduced and was in the early stages of development.
● Accident and incidents were recorded, and systems were in place for these to be reviewed and audited to enable trends to be picked up. However, we saw recurrent falls were not identified and actions were not taken to mitigate the risk of reoccurrence.

Risks to people were not identified and managed, and systems were not established to promote learning from incidents to mitigate risks to people. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately following the inspection with an action plan which showed how they would mitigate risks to people.

● The service had an external contractor who had completed an environmental risk assessment. Electrical equipment and gas safety checks were carried out and moving and handling equipment was serviced. People had personal emergency evacuation plans (PEEP's) in place and there was an emergency evacuation chair available.
● The service had identified potential issues with the roof space meeting fire regulations. However, contractors were appointed to review and rectify this. In the meantime, a recent fire drill had taken place to remind staff of the fire procedure and extra staff were provided day and night to mitigate potential risks.

Using medicines safely
● People were not always given their medicines as prescribed. Some people required the application of prescribed cream following support with personal care. Topical medicine application records indicated cream was only applied twice a day, which did not reflect the number of personal care episodes seen in daily records or that personal care needs were regularly attended too.
● Allergies were not accurately documented on people's care and medicines records. A person joined the service in August 2020 and the service received information from their GP and their previous residence. The information from the GP was not cross checked on the person's arrival, and the person's allergies had been incorrectly recorded. This was later identified by a visiting professional and rectified by the service.
● Some people using the service required support with as and when required medicines. One person using

the service was prescribed paracetamol as required however, was receiving this regularly up to three times per day. The service had not identified this pattern and therefore had not requested a medication review, to determine if this arrangement for pain relief remained safe and appropriate to continue.

● At our previous inspection we observed a member of staff disposing of liquid medicine down the sink plug hole. At this inspection we found the service had failed to implement the safe disposal of liquid medicines. We observed a single jam jar used to dispose of three different forms of liquid medication. There can be a risk of reaction when mixing different types of liquid medicines, and best practice guidance requires medicines to be stored securely in a tamperproof container until they are collected or taken to the pharmacy for disposal. The interim operations manager advised he had requested the order of suitable containers.

We found evidence safe medicine practices were not promoted. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately following the inspection with an action plan which showed how they would rectify the issues we had identified in relation to medicine practices.

● We observed the ordering and storage of medicines, including controlled drugs, was conducted safely. Medicines trolleys were not left unattended and were secured to the wall when not in use.

● A health professional told us the service had been proactive in setting up proxy access for medication ordering for people, which is mostly done online. This had made medication ordering efficient and avoided wastage of medications. They told us people's medicine use was kept under review and commented " The medication review dates are always highlighted to me when they are due and this has ensured that none of the residents are on any unnecessary medications."

Preventing and controlling infection

● We were not assured that the provider was preventing visitors from catching and spreading infections. On arrival a member of staff carried out a temperature check which was recorded. The provider's policy identified five questions visitors should be asked to identify signs of infection or recent contact with others who have symptoms of COVID-19. We were not asked any of these questions before or after entry to the service. Visitors were asked to wear personal protective equipment (PPE) on entry.

● We were not assured that the provider was using PPE effectively and safely. The service had sufficient stocks of PPE. We raised concerns regarding the proximity of the donning and doffing area to the sluice. There was inadequate signage to advise staff how to safely don and doff PPE within this confined area, which was a risk of cross infection. We also observed two kitchen staff working together without the use of face masks. This issue had previously been raised through whistleblowing concerns, but we found had not been appropriately monitored and the deputy manager advised they would initiate spot checks. Staff received infection control training, however staff were not observed to be following best practice, such as staff wearing jewellery and not wearing PPE as outlined above.

● We identified concerns in relation to the testing process at an earlier stage of the pandemic. Staff meeting records indicated the registered manager had continued to work on site after developing potential symptoms of COVID-19 and seeking a test. The positive test result was delayed and received seven days after the individual first developed symptoms. The failure to self-isolate could have posed a risk to staff and people using the service. The provider confirmed after the inspection that the registered manager had a test as other staff had tested positive rather than them being symptomatic. This explanation does not correspond with the staff meeting minutes around the incident.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. COVID-19 disinfecting schedules required staff to disinfect frequently touched, high risk areas three times per day. The records we reviewed showed several missed signatures, indicating some areas of the home had only been sanitised once on some dates. Schedules for cleaning of equipment including walking aids also showed omissions. A deputy manager confirmed they were aware of this issue but had not changed the process to ensure a designated member of staff would be responsible for this task on each shift. After the inspection the provider sent evidence that systems had been put in place, for the senior team to monitor cleaning schedules to ensure the required cleaning was carried out.

● The service had not considered how spaces could be ventilated as part of infection control measures, fans were in use which increased the risk of spreading the infection due to the lack of ventilation, and communal spaces did not promote social distancing. The rotas showed some staff worked across the units without consideration of the risk of cross infection. We also observed that staff brought personal belongings such as coats and handbags onto the units which could pose a risk of infection. The interim operations manager addressed the practice of staff belongings on units during the inspection to minimise the risks of cross infection.

The service had failed to ensure appropriate infection control measures in response to the COVID-19 pandemic. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection with an action plan which outlined how they would improve infection control measures.

● We were somewhat assured that the provider was accessing testing for people using the service and staff. The deputy manager confirmed regular testing was taking place and we observed a supply of testing kits. Staff were asked to share their test results to provide evidence of a negative result. Some people using the service could not consent to COVID-19 swab testing. Where staff believed a person was unable to give informed consent, the service documented a mental capacity assessment and best interests decision.

● We were somewhat assured that the provider was meeting shielding and social distancing rules. The service had considered the risk posed by COVID-19 towards people using the service, and identified individuals at greater risk, such as those with diabetes. The service had also identified staff members at greater risk, including those shielding, and where required documented a risk assessment. We did not observe social distancing encouraged for people using the service. We observed staff serving meals to individuals seated opposite one another on small dining tables.

● We were somewhat assured that the provider was admitting people safely to the service. The deputy manager provided verbal assurances regarding the current approach to admissions, explaining this would include a COVID-19 test prior to admission and a 14-day isolation period, even if the test result was negative. Prior to our inspection concerns had been raised regarding the admission of a person who did not remain onsite for isolation, and instead had left the service to spend time with a family member and access public spaces. The deputy manager informed us the service had learnt from this incident and improved their admissions process.

● We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed. The deputy manager provided assurances that agency staff access regular COVID-19 testing onsite and do not work on other sites. The manager also provided verbal assurances that people

using the service who presented with symptoms or tested positive for COVID-19 infection would be isolated to prevent the spread of infection. A written procedure could not be located at the time of inspection, and we have requested follow up evidence of isolation protocols in place.

● We were somewhat assured that the provider's infection prevention and control policy was up to date. The policy had been updated in response to COVID-19 and we also reviewed a document which provided a summary of checks for visitors, staff starting their shift and new admissions. We have requested additional documentation to review the provider's procedures in relation to isolating symptomatic residents.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the service had failed to report and appropriately respond to allegations of abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

● Allegations of abuse and omissions of care were not always dealt with appropriately. Records showed staff had failed to provide thickened fluids for a person using the service on several occasions. The service had not adequately addressed this ongoing issue and neither the safeguarding team or the Care Quality Commission (CQC) had been informed of these omissions of care. This had left the person at risk of harm over a period of several months.
● The service had failed to identify other safeguarding concerns we found, including an incident of unexplained bruising. Another individual was at risk due to a pattern of self-neglect. This had not been identified or reported as a potential safeguarding concern, and we found the person remained at risk.
● The provider had policies in place in relation to safeguarding and whistleblowing concerns. Some staff we spoke with were aware to report poor practice or other concerns for people's safety. However, when allegations had been raised regarding the conduct of a member of staff, we found no evidence action had been taken to investigate the concerns or consider the potential risk to people using the service.
● The culture of the service did not encourage the open and transparent reporting of concerns. We reviewed staff meeting minutes which discussed safeguarding and whistleblowing. Management comments described whistleblowing as a problem and cowardly thing to do, rather than an opportunity to learn, improve practice, and safeguard people using the service. The documented comments within the team meeting minutes had the potential to discourage staff from reporting future concerns. After the inspection the provider provided us with a copy of a letter sent to all staff to encourage them to speak up and provide open and honest feedback in line with the providers whistleblowing policy.

We found evidence people were at risk of harm, systems were either not in place or robust enough to identify and effectively respond to concerns of abuse or neglect, including self-neglect. This was a continued breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately following the inspection with reassurances that they would investigate the concerns we identified and the required local authority safeguarding alerts and CQC notifications were then submitted soon after the inspection.

Staffing and recruitment

● Safe recruitment procedures were not consistently implemented by the registered manager to ensure staff were suitable. We saw disclosure and barring checks were carried out on potential new staff, but the records did not always show that the barring list was checked.
● We reviewed staff recruitment records. One candidate had not been asked to provide a full employment history and another candidate's application showed a gap in employment which had not been explored as part of the recruitment process.
● At our previous inspection, a candidate had written their employment histories on their application form, but the dates did not correspond with the dates given on a reference provided by the previous employer. On this inspection we found the same concern for a different staff member and brought this to the attention of the interim operations manager. One of the staff files viewed had no photo on file.

Systems were not robust enough for the safe recruitment of staff. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded to our feedback and agreed to commence auditing of recruitment files.

● The rotas showed sufficient staffing levels were maintained to meet the needs of the number of people the service was supporting. Staff felt the current staffing levels were suitable, although some staff indicated there was a high agency use at the weekends which put added pressures on the permanent staff. The rotas viewed confirmed this was the case.

We recommend the provider consider best practice guidance around staff deployment and skill mix.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection good governance was not established. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made and the provider is still in breach of regulation 17.

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

- The service had a long-standing registered manager and deputy manager. However, they failed to manage and audit the service effectively. The registered manager and deputy manager were office based and had delegated the running of the home to senior staff without oversight of tasks, responsibilities or ensuring that staff had the skills and training to carry out the roles. For example, senior staff were responsible for assessing potential new referrals to the home, care planning, risk assessments, inducting and supervisions of staff as well as managing the day to day shift.
- The registered manager and deputy manager did not have a presence on the units and did not monitor staff practice. They did not work on the rota or act as positive role models to staff. Staff told us they felt well supported by the senior team, but some staff felt the registered manager and deputy manager did not work as part of a team. A staff member commented, "We only see the deputy manager when we have done something wrong and she comes to tell us off."
- Systems were in place to audit the service. However, the auditing was not carried out in line with the provider's schedule on audits. The audits that had taken place were ineffective as they had not picked up the issues we found in relation to care planning, risk management, medicines and the Mental Capacity Act 2005. A sample of care plans and medicines were to be audited monthly. The care plan audits available were of two care plans audited in June 2020. The registered manager told us other audits of care plans were carried out, but the audit reports were not on file or available to us. The medicine audits on file were dated July and October 2020 and not monthly as required by the provider.
- Other aspects of the service were audited including catering, housekeeping, infection control and health and safety. Each audit contained an action plan, but the actions were not delegated or signed off as completed. During our tour of the environment we saw a free-standing heater in the corridor. The interim operations manager confirmed they had picked this up on their health and safety audit on the 11 November 2020 and had given the registered manager verbal feedback on the audit which included asking them to remove the free-standing heater. This had not been acted on but, was removed during the inspection. Infection control audits had not picked up that cleaning schedules and the weekly cleaning and checks of mobility aids were not signed off as completed.

● Staff recruitment files were audited but issues we identified were not picked up and where actions were required there was no evidence these were always followed up and acted on. A training and supervision matrix was in place which showed gaps in training and supervisions. Some staff we spoke with advised they did not receive regular supervision. Records we reviewed showed staff received supervision at varying intervals, and staff induction records were incomplete. This was not in line with the provider's own policies for the recruitment, training and supervision of staff.
●The provider carried out a service audit in March 2020. From their audit a number of issues were identified which indicated improvements were required to care planning and risk management. The registered manager's action plan in response to the audit showed they disputed some of the interim operations manager's findings and indicated all actions were commenced, completed or on going. Our inspection findings showed the required improvements were not made or in progress.
● The home's action plan indicated all CQC previous actions were implemented and therefore the timescale for completion was not applicable. However, we found this was not the case and the provider was in continued breaches of regulations of the Health and Social Care Act 2008 and had not met a warning notice for breach of regulation 12 of the Health and Social Care Act 2008.

People were not cared for in a service that was effectively managed and monitored. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care, Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The registered manager had been in post since December 2015. The service has had a requires improvement rating for the previous three inspections. They had been in continued breach of regulations and the registered manager had failed to learn and improve care to provide a safe service to people.
● The service had people and relative survey results recorded for 2020. These showed people and relatives were happy with the service. Where suggestions for improvement were made, there was no evidence these were followed through and addressed.
● There was evidence of some engagement with relatives during the COVID-19 pandemic. However, at the time of the inspection no arrangements were in place for relatives to be able to visit people. As a result, visits from families were not taking place, except for people receiving end of life care.
● Staff meetings took place, although the frequency and scheduling of staff meetings were not regular. Shift leader books and handover records were in use. However, key information and changes for people were not routinely acted on and therefore communication was not effective. For example, staff had identified and recorded a person's skin had become very sore, but this was not acted on.

The service was not managed effectively to promote learning and good communication. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Systems were in place for staff to raise concerns. However, where concerns were raised there was no indication they were addressed. A staff member told us concerns they had raised had not been dealt with. They commented, "Concerns fall on deaf ears."
● The team meeting minutes facilitated by the registered manager showed that complaints and concerns were not seen as an opportunity for improvement to achieve good outcomes for people. Instead the registered manager had recorded that whistleblowing concerns and complaints were seen as a problem.

This had the potential to discourage staff from raising concerns which put people at risk.

● Records were not suitably maintained and accurate. People's records were contradictory throughout. For example, one section of a person's care plan indicated the person had a low risk of falls but elsewhere in their care plan it indicated they were at a high risk of falls. For another person a risk assessment indicated they needed to use a frame as opposed to a walking stick for mobility. The moving and handling risk assessment indicated the person mobilised with a stick.

● Some people had food and fluid charts in place. There were no fluid targets outlined for people and fluid charts were not routinely completed. One person's fluid intake ranged from a minimum of 125 millilitres a day up to a maximum of 775 millilitres a day. For people at risk of pressure area damage their mattresses were to be checked daily. We saw gaps in the recording of the mattress checks which had the potential to put people at increased risk of pressure area damage. A person's care plan indicated staff were to monitor urine and bowel movements. There was no explanation why this was required and monitoring charts were not in use to indicate this was being recorded.

● Care plans were not detailed and specific as to the care people required. They indicated people were to be supported with their personal care. Alongside this, records were not routinely completed to show if people had been supported with personal care or not. One person's care plan referred to them by two other names.

● Staff told us they had conversations with the registered manager around concerns for people's care and well-being. However, records were not maintained of those discussions and action taken to minimise risks to people. As a result, risks to people were not mitigated.

Records were not accurate and suitably maintained. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took immediate action to mitigate risks to people. They updated people's care plans and provided us with an action plan as to how they would improve their monitoring and management of the service. A registered manager from another location was brought in on a temporary basis to manage the service and start to address the issues we found.

● Staff involved in mental capacity assessments were trained. However, the records viewed indicated a lack of understanding and application of the Mental Capacity Act 2005.

● People's care plans included a mental capacity assessment which indicated if a person had capacity to make decisions on them living at the service. Where it was deemed a person did not have capacity, mental capacity assessments were completed. However, these were not decision specific and records were not always maintained to show that a decision was made as part of a best interest decision. For example, people who were assessed as not having capacity did not have mental capacity assessment for medicine administration or support with personal care which they resisted.

● A person's care plan indicated they were unable to manage their finances. However, there was no mental capacity assessment or best interest decision recorded to indicate how their finances would be managed. Another person had a mental capacity assessment in place which indicated they were unable to manage their finances. There was no power of attorney in place and no best interest decision recorded.

● A person moved into the service at the end of July 2020. A Deprivation of LIberty Safeguards (DoLS) application was made on the 3 August 2020 but the mental capacity assessment and best interest decision record in relation to them living at the service was not completed until the 21 August 2020.

This is a breach of regulation 11 (Consent to care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider failed to make the required notifications to us in a timely manner. This

was a breach of regulation 18 (Registration Regulations 2009).

Enough improvement had not been made and the provider is still in breach of regulation 18 (Registration Regulations 2009).

● Providers and registered managers are required to notify us of certain incidents which have occurred during, or as a result of, the provision of care and support to people. Safeguarding incidents had not been considered as potential safeguarding concerns. Therefore, the required safeguarding notifications were not reported to CQC in a timely manner.
● For some notifications made there was a delay in reporting. For example, an incident occurred on the 27 April 2020 and we were not informed until the 15 May 2020. Another incident occurred on the 12 September 2020 and we were not informed until the 21 October 2020.

This was a continued breach of regulation 18 (Registration Regulations 2009). The provider responded immediately after the inspection and made the required notifications to us in respect of incidents that should have been reported.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had a duty of candour policy in place. In serious injury notifications received we saw duty of candour had been ticked to indicate they had notified the relevant person about the incident. Not all of those incidents were a duty of candour incident. The provider confirmed the next of kin was informed of the incidents, but they were unable to evidence that a written response had been provided as is required under the duty of candour regulation.

This is a breach of regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection the interim home manager agreed all notifications would come through them to review if a response was required under the duty of candour regulation.

Working in partnership with other
● Prior to the COVID-19 pandemic we were told the service was actively involved in the local community and local school children came to the service. This had stopped in line with the restrictions imposed on visitors to the home.
● The service worked closely with a GP surgery and the district nurse team. During the inspection we saw a district nurse visited the service to review individuals.
● A relative told us they felt well informed of arrangements during lockdown and received weekly briefings. They confirmed they call their family member daily and skype calls were tried, although their family member was not keen on them.
● Two professionals told us they had a positve relationship with the service. One professional told us changes are communicated to them in a timely manner. The other profressional told us the service was one of the first care homes in Buckinghamshire to implement the Situation-Background-Assessment-Recommendation (SBAR). This technique provides a framework for communication between members of the health care team about a patient's condition. They told us senior members of the team were trained in using a blood pressure machine, thermometer and pulses oximeter. They commented "Swan house were keen to help."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to recognise incidents that needed reporting to us , and for other notifications there was a delay in the notifications been made.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Records showed the service did not work to the principles of the Mental Capacity Act 2005

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe recruitment practices were not promoted.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The service did not work to the duty of candour regulation and the providers policy, to ensure openness and transparency when things went wrong.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safe care and treatment was not provided to minimise risks to people.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not safeguarded from the risk of abuse.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service was not effectively managed and good governance was not established.

The enforcement action we took:

We served a warning notice.