Flightcare Limited

Swansea Terrace

Inspection report

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Date of inspection visit:
02 August 2017
07 August 2017

Date of publication:
17 October 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Swansea Terrace is registered to provide 24 hour nursing and personal care for up to 44 people and is located close to Preston city centre. There are two large communal rooms, communal bathrooms and en-suite washing facilities. At the time of our inspection there were 31 people who lived at the home.

The last inspection of this service took place over two days on 02 and 06 June 2016. The service was awarded a rating of 'Requires Improvement' and we identified no breaches of regulation at this inspection.

This inspection visit at Swansea Terrace was undertaken on 02 and 07 August 2017 and was unannounced.

The service is required to have a registered manager in post. 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. At the time of our inspection the service did not have a registered manager. A manager had been employed who was in the process of registering with CQC.

During the inspection the environment was found to be unclean in a number of areas. We found there were no clinical waste bins where these were required. We saw bathroom equipment that was rusty. Some of the bins around the premises were overflowing and did not always contain a bin liner.

We observed unsafe practice when one member of staff was supporting a person who lived at the home with their lunch. The person was asleep and the staff member put food into their mouth and gently "shook" them awake to swallow it. This posed a high risk of choking for the individual.

We observed poor moving and handling throughout the inspection visit. People who required hoisting had full body slings which should be positioned level with the back of people's knees for support. However we observed this was not always the case.

We observed the lunchtime medicines round and found people were not asked if they required pain relief prior to being given pain relief medicines. In addition we noted one person refused one of their medicines. We checked the records and saw the persons medicines had not been reviewed to see if there was an alternative medicine they could take.

We looked at people's care plans and found gaps in information regarding people's medicine regimes. We saw support plans to guide staff when giving medicines which are taken "as needed". However these did not contain all the relevant and necessary information for the staff to give the medicines appropriately and safely.

Topical cream administration was found not to be safe. The topical cream charts were inconsistent. We

found instructions for the topical creams had not been transferred to the cream charts accurately. This resulted in creams not being applied as directed.

The concerns with infection control, medicines management and unsafe practices amounted to a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of the report.

Staffing levels were observed to have direct impact on peoples care and treatment. Although people told us they felt safe, everyone we spoke with raised concerns about staffing levels.

The concerns we found with staffing arrangements amounted to a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

We asked to look at the recruitment records for three people who worked at the home and found the provider had not made sure suitable referencing was obtained prior to agreement of employment.

The concerns we found with recruitment amounted to a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of the report.

People's privacy and dignity were not always respected and promoted. We observed very little interaction between staff and residents during our inspection visit. Interactions were task focused; we observed two incidents which impacted on people's dignity.

The above concerns amounted to a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of the report.

Person centred information was not always followed; we found that people were not being bathed in accordance to their wishes.

The above concerns amounted to a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of the report.

Systems were completed to demonstrate regular checks had been undertaken looking at care files and daily records. However, checks were not always robust and effective. The provider had not ensured the processes they had to monitor quality and identify areas for improvement were effectively implemented. We found examples of audits which had been completed in June 2017 however the actions documented had not yet been acted on.

These shortfalls in quality assurance amounted to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance). Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

We made a recommendation around maintenance safety checks.

We made a recommendation around complaints and informal concerns.

The care records we looked at told us about people's dietary preferences. People told us they were able to make choices in relation to food and drink and we observed them being offered a variety of options. People we spoke with said, "The food is not bad, they will accommodate you."

There were activities for the people to engage in and people were supported and encouraged to take part. One person told us, "I like living here and being involved in the activities, my family visit when they can."

We received positive feedback about staff from people who lived at Swansea Terrace. One person told us, "Staff are very good with me, they are kind." Another person said, "I love all the staff, they look after me."

Staff supervision was not always consistent at the service. Some of the staff we spoke with said they had not received supervision for some time and documentation supported this. We noted supervisions were undertaken following incidents and was reactive rather than proactive. One member of staff we spoke with told us they had never received supervision in their time at the service. However staff told us that they felt supported in their role.

People told us the manager at Swansea terrace was approachable. One relative told us, "The new manager is approachable." One staff member told us, "I like the manager; I get on well with them. They are approachable and very helpful with personal stuff as well as work."

We found the management team receptive to feedback and keen to improve the service. The managers worked with us in a positive manner and provided all the information we requested.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Staff were aware of the provider's safeguarding policy and how to report any potential allegations of abuse or concerns raised and were aware of the procedures to follow.

There were not always adequate numbers of suitably qualified staff deployed to meet people's needs. There were recruitment procedures in place. However, these were not always followed in a consistent manner.

There were shortfalls in infection control and unsafe practices which placed people at risk of harm.

Medicine administration documentation was not always fully completed by staff.

Is the service effective?

Requires Improvement

The service was not always effective.

Some examples of effective nutritional support were seen. However, we also found an example where one person had experienced weight loss over periods of several months and no action was taken.

People's rights were protected, in accordance with the Mental Capacity Act 2005.

We saw evidence that people received the support of other health care professionals such as the doctor, dietician or speech and language therapist.

Is the service caring?

Requires Improvement

The service was not always caring.

People who lived at the home were very complimentary about the staff and they told us they were happy with the care and support they received. However we observed people's privacy and dignity were not always respected and promoted.

People had their own bedrooms and had been encouraged to bring in their own items to personalise them.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

People told us the staff were not responsive to their individual needs.

People we spoke with said they did not feel confident any complaint would be taken seriously and fully investigated.

There were activities for the people who lived at the home to engage in and people were supported and encouraged to take part.

Is the service well-led?

Inadequate

The service was not well led.

Over a two year period there has been instability within the management at the service.

Systems in place to monitor the standard of service and the safety of people who lived at the home were not effective.

People's views were not always acted upon in a timely manner.

We found multiple breaches of the regulations.

Staff members we spoke with reported a positive staff culture. Staff worked in partnership with other professionals to make sure people received appropriate support to meet their needs.

Swansea Terrace

Detailed findings

Background to this inspection

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

This inspection visit at Swansea Terrace was undertaken on 02 and 07 August 2017 and was unannounced.

The inspection team consisted of two adult social care inspectors and an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service. This expert had experience of caring for older people.

Prior to our visit, we reviewed all the information we held about the service, including notifications the provider had sent us about important things that had happened, such as accidents. We also looked at information we had received from other sources, such as the local authority and people who lived at the home.

The provider returned the completed Provider Information Return (PIR), within the requested timeframes. A PIR is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We reviewed this information as part of the inspection.

As part of the inspection visit we spoke with 12 people who lived at the home and four relatives. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We did this to gain an overview of what people experienced whilst living at the home.

We spoke with the manager, deputy manager, quality manager and three staff members.

We closely examined the care records of six people who lived at the home. This process is called pathway tracking and enables us to judge how well the service understands and plans to meet people's care needs and manage any risks to people's health and wellbeing.

We reviewed a variety of records, including some policies and procedures, safety and quality audits, three staff personnel and training files, records of accidents, complaints records, various service certificates and medication administration records.

We observed care and support in communal areas and walked around the building. This enabled us to determine if people received the care and support they needed in an environment that was appropriate.

Inadequate

Is the service safe?

Our findings

People we spoke with said, "I can say I feel quite safe." And, "I feel safe living here."

During the inspection, the environment was found to be unclean in a number of areas. We found that there were not clinical waste bins where these were required. We saw bathroom equipment that was rusty. Some of the bins around the premises were overflowing and did not always contain a bin liner. We found that staff were not always disposing of personal protective equipment in the correct bins. In addition we found that all en-suite bathrooms were being used to store incontinence aids.

We raised the infection control and cleanliness issues with the manager and the quality manager. They told us that a full home audit had been undertaken and the manager was in the process of addressing areas identified for improvement. However the audit had taken place in June 2017 this had not been followed up on due to staff leave so the action remained outstanding.

These shortfalls in infection control arrangements amounted to a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed unsafe practice when one member of staff was supporting a person who lived at the home with their lunch. The person was asleep and the staff member put food into their mouth and gently "shook" them awake to swallow it, this posed a high risk of choking for the individual. We raised this immediately with the management team, the staff member was taken off meal time duties and the manager completed a reflective supervision with the staff member.

We observed poor moving and handling throughout the inspection visit. People who required hoisting had full body slings which should be positioned level with the back of people's knees for support. However we observed this was not always the case. We asked staff who told us they were aware of the correct practice but people slide down the slings therefore the slings are not always positioned behind people's knees. We were informed by a senior carer if someone slides they would be re-hoisted using a toileting sling to reposition onto the full body sling. We did observe this happen however this was not always done for each person on transfer.

These shortfalls and unsafe practices amounted to a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at medicine administration records of people who lived at Swansea Terrace. Records showed medicines had been signed for. We checked this against individual medicines packs which confirmed all administered medicines could be accounted for. This meant people had received their medicines as prescribed. However we observed the morning medicines round was on-going at 11.30am during our inspection visit. We spoke with the manager who informed us this was not usual practice and it should have been completed earlier. This meant people did not receive their medicines at the correct time on this day.

We observed the lunchtime medicines round and found people were not asked if they required pain relief prior to being given pain relief medicines. In addition we noted one person refused one of their medicines, the staff member advised us the person does not like the texture of this medicine and so doesn't take it. We checked the records and saw the persons medicines had not been reviewed to see if there was an alternative medicine they could take.

We looked at people's care plans and found gaps in information regarding people's medicine regimes. We saw support plans to guide staff when giving medicines which are taken "as needed". However these did not contain all the relevant and necessary information for the staff to give the medicines appropriately and safely. This could have put people at risk of medication mismanagement.

We spoke to the manager about this and they informed us the new medicine support plans had been completed and should have been present in people's medicines files. Following the inspection the manager confirmed to us these plans are now in place and we were sent a sample of the documents.

Topical cream administration was found not to be safe. The topical cream charts were inconsistent. We found instructions for the topical creams had not been transferred to the cream charts accurately. This resulted in creams not being applied as directed. The person administrating these treatments should have clear direction and demonstrate accountability by signing administration records.

Controlled medicines were kept separate in a secure cupboard; records for these medicines were completed in full.

These shortfalls in medication arrangements amounted to a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing levels were observed to have direct impact on peoples care and treatment. Although people told us they felt safe, everyone we spoke with raised concerns about staffing levels. People who lived at the home said there were not always enough staff on duty. One relative said, "Truthfully there could be more staff." One member of staff said, "We are chronically short staffed." Another told us, "At times we have enough, sometimes don't; sometimes can't get agency to cover, so end up working short staffed." A third said, "The staff are really struggling. People are not getting showered because they physically can't do it."

We observed one person being told to wait to have their incontinence needs met due to staffing levels, people we spoke with confirmed to us this happened regularly. Comments included, "When I ask to go to the toilet I am told, you will have to wait." And, "I am told, there's no one available to take you to the toilet." Also, "I have a commode in my room because the toilet is too low, I can manage on the bathroom toilets during the day but at night I need help, I can press my buzzer but they don't come so I use my pad."

We reviewed the staff rotas and the dependency tool which was being used. The dependency tool and rota's matched up. We spoke to the provider and the manager about this. The provider stated they provide staff in accordance to the tool and would not provide any additional staff unless the tool said they were needed. The manager stated they would do a full review of the dependency needs of people living at the home and look at the deployment and skill mix of the current staff team.

The concerns we found with staffing arrangements amounted to a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked to look at the recruitment records for three people who worked at the home and found the

provider had not always made sure suitable referencing was obtained prior to agreement of employment. One staff file did not contain any references and the DBS for this person listed a conviction which had not been risk assessed by the provider.

The concerns we found with recruitment amounted to a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We viewed maintenance records which had documented water temperatures of 46°C, 50°C, and 45°C. No action had been taken by the service as a result of these readings. The health and executive guidance states if hot water used for showering or bathing is above 44 °C there is increased risk of serious injury or fatality. Where large areas of the body are exposed to high temperatures, scalds can be very serious and have led to fatalities. We raised this issue with the manager on the day of the inspection and engineers were called to the site immediately to resolve the issue.

During our inspection site visit the fire alarm was tested, we observed one of the fire doors did not close. We checked the records and could not see any recorded checks on door guards to make sure they operated correctly. This was highlighted to the management on the day of the inspection and engineers were called to the site immediately to resolve the issue.

We recommend the service ensures maintenance safety checks are in place in accordance with national safety guidelines.

We saw one person had been losing weight over a four month period the person had lost 16.1kg. We spoke with the manager who stated people's weights are recorded and audited however this had not been recognised by them. We asked the manager to investigate the weight loss and complete a review of the persons needs to ensure the person was receiving the correct care. This was done following the inspection visit and evidenced to the inspector. The person had spent a prolonged period of time in hospital which contributed to their weight loss at this time.

Systems were in place to reduce people being at risk of harm and potential abuse. Staff had received up to date safeguarding training and understood the provider's safeguarding adult's procedures. They were aware of their responsibilities to ensure people were protected from abuse. Staff members we spoke with demonstrated they knew about the procedures they should follow if they were concerned people may be at risk.

Care records included detailed risk assessments, which provided staff with guidance on how risks to people were minimised. This included risks specific to each individual according to their daily activities and support needs. For example, a person who presented with swallowing difficulties had been assessed by a Speech and Language Therapist (SALT). They had provided guidelines for how to prevent the risk of this person choking. There were also measures in place to prevent possible complications of poor nutrition, such as a skin integrity care plan and regular weight measurements. We found that the home had no one with any pressure sores We saw risk assessments undertaken regarding falls, included footwear, environmental hazards and medicines management.

Under current fire safety legislation it is the responsibility of the manager to provide a fire safety risk assessment that includes an emergency evacuation plan for all people likely to be on the premises in the event of a fire. In order to comply with this legislation, a Personal Emergency Evacuation Plan [PEEPs] needs to be completed for each individual living at the home. We looked at PEEPs during this inspection and found people had up to date PEEPs in their files to aid safe evacuation.

Requires Improvement

Is the service effective?

Our findings

The care records we looked at told us about people's dietary preferences. People told us they were able to make choices in relation to food and drink and we observed them being offered a variety of options.

People we spoke with said, "The food is not bad, they will accommodate you." And, "There is a choice at breakfast and they book down what you want for lunch and tea." Another person said, "The foods good."

We observed lunch being served, people ate in a relaxed manner and they enjoyed their meals. The care records we looked at told us about people's dietary preferences. People told us they were able to make choices in relation to food and drink and we observed them being offered a variety of options. They told us if they did not like what was on offer, alternatives were also available. We observed people being offered drinks and snacks regularly throughout our visit.

We found examples across the care records we looked at of people being referred for external health and social care support and professional advice being followed. The service maintained good working relationships with health professionals and sought guidance when needed. One person told us, "They will get the GP out if I need it."

A relative informed us if their loved one needed to see a GP the staff would arrange it and they would be informed. We were also told the nurses will make arrangements for the podiatrist to visit. Another relative explained they knew the SALT (Speech And Language Team), physiotherapist and dietician visit and they are kept updated by staff.

We saw evidence in care files the service was making the required referrals and seeking support on how best to meet people's needs. We found evidence of the service engaging with other agencies to facilitate joint working. Visits with other professionals were recorded in the care files. These arrangements helped to ensure people consistently received the care they needed.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 and whether any conditions on authorisations to deprive a person of their liberty were being met.

We looked at how the service gained people's consent to care and treatment in line with the MCA. We discussed the principles of the MCA with the manager who was able to demonstrate a good understanding of the process and the associated DoLs. We found that action had been taken by the service to assess people's capacity to make decisions. We found written records to show considerations had been made to assess and plan for people's needs in relation to mental capacity.

Staff supervision was not always consistent at the service. Some of the staff we spoke with said they had not received supervision for some time and documentation supported this. We noted supervisions were undertaken following incidents and was reactive rather than proactive. One member of staff we spoke with told us they had never received supervision in their time at the service. However staff told us that they felt supported in their role. One staff member told us, I feel well supported."

We saw the service had a detailed induction programme for all new staff and staff were required to complete the induction prior to working unsupervised. This programme covered important health and safety areas, such as moving and handling. In addition there were courses on working in a person centred way and safeguarding. One staff member told us, "The induction and training is good and it prepared me for the role."

We found the service promoted staff development and had a rolling programme to ensure staff received training appropriate to their role and responsibilities. We asked staff if they received training to help them understand their role and responsibilities.

Requires Improvement

Is the service caring?

Our findings

We received positive feedback about the staff from people who lived at Swansea Terrace. One person told us, "Staff are very good with me, they are kind." Another person said, "I love all the staff, they look after me."

We spoke with visitors about the care their relatives received at the home. One relative told us, "Last Wednesday [my relative] had been put to bed and was having tea, it was curry and rice but staff had not sat them up enough so food was spilling everywhere and I had to change the bed". Another relative said, "I am happy with the care, the staff do their best."

During our inspection visit we noted the bathrooms had keypad locks on them and several of these were locked. We spoke with a staff member about this and they told us the bathrooms were kept locked and people had to ask when they wanted to use them. We raised this with management and they told us they should no longer be locked and asked the maintenance man to remove these. Management informed us that one of the doors was always unlocked to allow people to access the bathroom when needed.

People's privacy and dignity were not always respected and promoted. Staff told us about how they protected people's dignity, such as when helping them with personal care. They demonstrated they had a good understanding of the importance of maintaining people's dignity and treating people with respect.

However we observed very little interaction between staff and residents during our inspection visit. Interactions were task focused for example, "We are going to hoist you now." Or, "We are going to give you some pressure relief." During the day staff sat with people in the lounges but either completed documentation or spoke with each other. We heard staff speaking about future tasks such as which person they would put back to bed first or whose pad they would change next. This was not dignified as could be overheard by anyone in the lounge.

One person we spoke with told us, "They [staff] will knock and come in [the bedroom]; the majority don't wait to be invited in."

We observed an incident during the inspection where staff supporting a person with their continence needs had not noticed they had been incontinent and were sitting the person back into a chair in clothing which was not clean.

We also observed someone asking for support with their continence needs. The staff responded by telling them they would have to wait. We spoke with staff about this and they told us, "We had three more people to do then we would help them." When asked why there was an order they replied they, "Needed to get everyone done before tea came out". We then spoke to two further members of staff and asked how many times in any one day would people usually be assisted to use the toilet, the reply from both was, "Once."

The above concerns amounted to a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had their own bedrooms and had been encouraged to bring in their own items to personalise them. We saw people had bought in their own ornaments and rooms were personalised with pictures and paintings.

The manager was knowledgeable about local advocacy services which could be contacted to support people or to raise concerns on their behalf. Advocates are people who are independent of the service and who can represent people or support individuals to express their views.

People's end of life wishes had not always been recorded to ensure staff were aware of these. Where they were documented these were not always specific requests, we spoke to the manager about this and they recognised the need for further documentation around this.

Requires Improvement

Is the service responsive?

Our findings

People told us the staff were not responsive to their individual needs. One person told us, "If I want to lie down after tea, staff tell me I have to get changed into my nightie and stay in bed until the next morning; I can't get up again and go back to the lounge." Another said, "I want to go to bed at 19.30 but the staff say, wait a minute, wait a minute. It then gets so late you are waiting for the night staff so I buzz but they don't answer. I've got to wait for them to come and it gets to 21.10."

We saw some good examples of person centred care in care files. People's beliefs, likes and wishes were explored and guidance in these records reflected what staff and people told us about their preferences. Each record contained a comprehensive history of each person.

However the information was not always followed. We found people were not bathed in accordance to their needs and wishes. We checked the records for one person where recorded wishes stated they wanted a bath or shower weekly. The records indicated they had not had a bath or shower over a three month period from June to August. We then checked the records of another person and found this to be the same.

We spoke to the manager about this they told us this was picked up in an audit in June 2017 and a new system had been introduced. However they had not followed up on the system to check this was effective. We spoke to staff who told us, "Staffing levels mean we're not able to give showers or baths as frequent as we should do."

The above concerns amounted to a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were encouraged to raise any concerns or complaints they had. The service had a complaints procedure which was displayed throughout the home. People and their relatives told us they felt comfortable raising concerns if they were unhappy about any aspect of their care. People we spoke with said they did not feel confident any complaint would be taken seriously and fully investigated.

Relatives told us they had raised issues but felt nothing had been done to resolve the problems. One relative told us a set of dentures were missing. They told us the dentures went missing approximately 6 months ago and still their relative had to manage to eat normal food without teeth. Another told us about a clock which keeps going missing and re-appearing. These issues were not raised as formal complaints and so there was no record of these.

A system for recording and managing complaints was in place, we observed some complaints had been recorded and the system had been followed.

We recommend the provider records all complaints and informal concerns in order to address and evidence these accordingly.

There were activities for people who lived at the home to engage in. They were supported and encouraged to take part. One person told us, "I like living here and being involved in the activities, my family visit when they can." During the inspection we observed the hairdresser was in attendance and two activities assistants were giving manicures after lunch. During the morning one activities assistant was seen working one to one with a person who lived at the home. We also observed a priest serving communion to individual people in the lounge area.

We found assessments were undertaken by the manager and nursing staff prior to any person being accepted into the home. Assessments took place to ensure people's needs could be met by the service. People's initial assessments had been used as a basis on which to formulate a care plan.

Documentation was shared with other professional's about people's needs on a need to know basis. For example, when a person visited the hospital. This meant other health professionals had information about individuals care needs before the right care or treatment was provided for them.

Inadequate

Is the service well-led?

Our findings

People told us the manager at Swansea Terrace was approachable. One relative told us, "The new manager is approachable." One staff member told us, "I like the manager; I get on well with them. They are approachable and very helpful with personal stuff as well as work."

We asked the manager to tell us how they monitored and reviewed the service to make sure people received safe, effective and appropriate care. Systems were in place to demonstrate regular checks had been undertaken looking at care files and daily records. The manager provided us with evidence of some of the checks that had been carried out on a daily, weekly and monthly basis.

However checks were not always robust and effective. For example we found one person had been losing weight over a period of time and this had not been picked up by the processes in place to monitor this. This highlighted the need for oversight and monitoring that is robust to ensure the response is appropriate and without delay.

We found examples of audits which had been completed in June 2017 however the actions documented had not yet been acted on.

None of the people who lived at Swansea Terrace or relatives we spoke with could recall attending any meetings with the manager or filling out surveys/questionnaires. One relative was very clear when they said, "There are no relatives or residents meetings here, and we have not filled in any questionnaires." However we did see evidence that questionnaires had been sent out and completed in 2017. Responses from people who lived at the home included, "I would like more baths." And, "Staff aren't readily available for toilet use." I spoke with the manager about these and was told these had not yet been analysed and there was not an action plan in place.

These shortfalls in quality assurance amounted to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance).

The service is required to have a registered manager in post. Over a two year period there has been instability within the management at the service. At the time of our inspection the service did not have a registered manager. A manager had been employed who was in the process of registering with CQC.

During this inspection we found a number of concerns that had not been highlighted and addressed by the management. We found people did not have an accurate, complete and contemporaneous record in respect of medicines management that resulted in staff not having the correct information to care for people safely and in accordance to their needs.

We observed poor practice from staff in relation to moving and handling and meal support. People's privacy and dignity were not always respected and promoted. We observed very little interaction between staff and residents during our inspection visit. Interactions were task focused; we observed two incidents which

impacted on people's dignity.

Despite a dependency tool for staffing being in place we found that staffing levels had a direct impact on peoples care and treatment. Although people told us they felt safe, everyone we spoke with raised concerns about staffing levels. It was evident to us during the inspection that staffing levels were not appropriate to meet the current needs of people living at Swansea Terrace.

Staff meetings had been held to discuss the service provided. We looked at minutes of the most recent team meeting and saw topics relevant to the running of the service had been discussed. These included discussing safeguarding procedures, infection control and safety.

Despite the service being evidently short staffed we found all the staff members we spoke with reported a positive staff culture. Staff told us, "The majority of staff get on now. Morale has improved." And, "I love the job and I love the residents."

We looked at policies and procedures related to the running of the service such as, safeguarding, whistleblowing and medicines management. These were in place and reviewed annually.

We viewed evidence which demonstrated the views of people who use the service and staff had been sought and acted on for the purposes of continually evaluating and improving the service.

Providers of health and social care services are required to inform the Care Quality Commission, (CQC), of important events that happen in their services. The manager of the home had informed CQC of significant events as required. This meant we could check appropriate action had been taken.

The service had on display in the reception area of the home their last CQC rating, where people who visited the home could see it. This is a legal requirement from 01 April 2015.

We found the management team receptive to feedback and keen to improve the service. They worked with us in a positive manner and provided all the information we requested.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that people who used the service receive person-centred care and treatment that is appropriate, meets their needs and reflects their personal preferences, whatever they might be. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured that people using services were treated with dignity and respect at all times. Regulation 10 (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not have suitable arrangements to ensure medicines were managed in a safe way. Regulation 12 (1) (2) (g) The provider must ensure that staff follow plans and pathways to ensure that safe care and treatment of individuals. Regulation 12 (1) (2) (b) The provider did not ensure that the

environment was of a good standard of cleanliness. When assessing risk, providers should consider the link between infection prevention and control and cleanliness
12 (1) (2) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not operate robust recruitment procedures. Regulation 19 (1) (2) (a) (b)