Swanton Care & Community Limited

Swanton House Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 19 and 20 April 2017 and was unannounced.

Swanton House Care Centre provides residential and nursing care for up to 49 people. It is divided into three units. Holly Court and Bluebell are single story and purpose built. Birch is a converted period building. Some people who used the service needed support with their mental health needs. For other people their needs were age related or they were living with dementia.

Both Birch and Holly Court provided nursing care whilst Bluebell provided residential care only. Those people requiring care for their age related conditions or support whilst living with dementia, lived in Birch. At the time of our inspection there were 48 people living in the home.

At the time of our inspection, there was no 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.

An application to register one of the service managers had been received by CQC and, at the time of this inspection, was being processed. However, shortly after the inspection, we received confirmation that this service manager intended to withdraw their application. They were present at this inspection.

We last inspected this service over March and April 2016 where we found that the service was not meeting one requirement of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach related to meeting people's nutritional and hydration needs. The provider sent us a plan to tell us about the actions they were going to take to rectify the breach of the regulations. They told us these would be completed by June 2016. At this inspection, carried out in April 2017, we found that the service had made some improvements in regards to meeting people's nutritional needs and were no longer in breach of this regulation.

Six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified at this inspection carried out in April 2017. These breaches related to safe care and treatment, safeguarding people from abuse and improper treatment, the need for consent, staffing, person centred care and good governance.

The provider was already aware of the issues we identified at this inspection and action plans were in place to address them. However, the concerns had been evident for some time and insufficient action had been taken to rectify them in a timely manner.

A reduced management team had had an adverse impact on the service and there were not enough resources in place to ensure a consistently good quality service was being delivered. The processes for

assessing, monitoring and improving the service had not been effective.

People did not consistently receive care and support that was tailored to their individual needs. Care plans lacked accurate, up to date and person centred information that reflected people's needs. The social and leisure needs of all those that used the service were not being met.

Risks were not always fully mitigated and managed. Clear strategies for supporting people living with behaviour that may challenge them and others were not consistently in place. The procedures in place to safeguard people were not fully effective. Staff were stretched to support people in a safe and dedicated manner.

Medicines management arrangements had not been regularly reviewed and audited and some people had not received their medicines as the prescriber had intended. This put people at risk of a decline in their mental and physical wellbeing.

Records contained gaps in regards to managing people's nutritional needs and there was confusion over how this was managed. There was no clear process in place to effectively monitor, assess and analyse people's nutritional and hydration intake. People had access to healthcare professionals as required. However records did not demonstrate how, when or if any issues were followed up in relation to healthcare needs.

The CQC is required to monitor the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS) and report on what we find. People's human rights had not always been respected and the service had not been fully compliant with the Act.

Staff received an induction and regular support and supervision. However, considerable amounts of staff training were overdue and the competencies of staff to perform their roles were not assessed. Clinical staff had not been assessed in regards to their practice and also lacked up to date training. Consequently, the provider could not be assured that people were receiving safe or effective support.

Processes were in place to ensure that only those that were suitable to work in the service were employed. However, some staff raised concerns about the provider's ability to recruit suitable managers due to the recent turnover.

Staff demonstrated a polite, respectful and caring approach although they were often too busy to engage and interact with people for more than a brief moment. People's dignity was maintained and records were stored confidentially. People had some choice in their daily living but this was limited. People were not actively supported to achieve their goals and aspirations and not always included in planning the care and support they received.

The staff team demonstrated that they were supportive of each other and those that used the service. They were understanding of the constraints the management team were under and showed support to them. Staff morale was variable, as was team work, however staff showed us that they were committed to each other, those living in the home and the service.

A complaints policy in place to address any concerns people may have. Staff and those that used the service said they would feel comfortable in raising any concerns. There were no restrictions on the times people's friends and relatives could visit them.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The service had not obtained a number of medicines in time to administer to some of those using the service. This jeopardised their mental and physical health and wellbeing.

The procedures the service had in place to help protect people from the risk of abuse or harm were not fully effective.

People's basic needs were met but staff didn't consistently have time to fully interact with those living at the home.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Compliance with the MCA was variable and records did not evidence consistent adherence.

People had choice in what they had to eat and drink but improvements were required in relation to people's meal time experience.

The provider had not ensured that staff received the necessary training and clinical nursing competencies had not been assessed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The service couldn't demonstrate that people had been involved in planning the care and support they received.

Staff supported people's choice and independence although this was limited. People's dignity and privacy was maintained.

The staff approach was respectful, caring and polite but interactions were often brief.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's basic needs were met but they did not receive care and support in a person centred manner.

The social and leisure needs of those that used the service were not consistently met.

The service had a complaint policy in place to address any concerns people may have.

Is the service well-led?

Inadequate

The service was not well-led.

A system was in place to monitor the quality of the service but this had not been effective.

The provider was aware of the issues within the service and had an action plan in place however concerns hadn't been rectified.

There were not enough management resources in place to ensure a good quality service was delivered and no one manager had overall responsibility.

Swanton House Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 19 and 20 April 2017 and was unannounced. Three inspectors and an expert-by-experience carried out the first day of the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day of inspection was carried out by one inspector.

Before we carried out the inspection we reviewed the information we held about the service. This included statutory notifications that the provider had sent us in the last year. A statutory notification contains information about significant events that affect people's safety, which the provider is required to send to us by law. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We had also liaised with the local authority safeguarding team and the local authority quality assurance team leading up to the inspection.

During our inspection we spoke with 17 people who used the service and two relatives. We also spoke with the provider's director of governance and quality, the two service managers responsible for managing the three units (one of whom had recently applied to be registered with CQC), one registered manager of another service owned by the provider, three nurses, one agency nurse, one team leader, the hospitality services lead and seven support workers. Some of these conversations were brief. We observed care and support being provided to the people who used the service on both days. Following our inspection visits, the service submitted further records within the stated timescale.

We viewed the care records for nine people who used the service. We also looked at the medicine administration records and associated documentation for eight people. All of the medicine administration records for those living in Holly Court were briefly viewed. We also looked at records in relation to the management of the home. These included staff personnel files, minutes from meetings held, staff training

records, quality monitoring information and maintenance records.

Requires Improvement

Is the service safe?

Our findings

Four people living in Holly Court had not received their medicines as prescribed. This was due to their medicines not being obtained in time by the service in order to administer. One of these four people had not received their medicines for ten consecutive days. For others, their medicines had been omitted for between four and nine consecutive days. The failure to administer medicines as the prescriber had intended had put these people at risk of declining mental or physical health.

One person had complex mental health needs. A care plan was in place that gave staff guidance on how best to support this person in order to maintain their mental wellbeing. However, we saw that a number of incident forms had been completed in response to behaviour that may challenge others. For one of these, the service had recorded this person as becoming 'very frustrated, angry and irritable' on one occasion. Records showed that the person had thrown an object and self-harmed as a result. Although clear guidance was available to staff, this had not been followed which resulted in the person being at the risk of harm to themselves and others.

Another person had recently had a change to their nutritional needs and required a pureed diet in order to mitigate the risk of choking. However, records showed that this had not been consistently provided. When we discussed this changed need with staff, not all were able to accurately tell us what diet the person required and there was confusion as to what constituted a pureed diet. This put the person at risk of receiving unsafe care and treatment.

Further discrepancies were found in relation to the management of people's nutritional needs and no clear process was in place to either manage or monitor this. When we asked a service manager what the process was in relation to people's nutritional need, they told us that food and fluid charts were only used where a clinical need had been identified. A white board in the care office of Birch showed that five people who used the service were on a food and fluid chart. We checked the care records for one of these people. Their nutritional care plan, dated 20 March 2017, also stated that a food and fluid chart was to be completed however no charts could be found. When we asked the nurse in charge where these were located, they told us that no one living in Birch was currently on a food and fluid chart. When we questioned the information on the white board, they told us this was incorrect and had not been updated.

We asked the nurse in charge how the service managed and monitored the risks associated with dehydration and nutrition. They told us that each person had a daily target amount for fluid intake which was visible in the care office. When we asked how this was monitored they told us that this was completed by making observations of individuals. A service manager had informed us that daily fluid amounts should be recorded in people's care notes on a daily basis. They told us that should these fall below the targeted amount, then actions taken by staff in response would be recorded. However, although the daily notes we viewed often recorded what people had to eat and drink, no accurate measurement was recorded. This method was not effective and gave no clear and consistent overview of a person's nutritional intake meaning potential issues could not be easily or quickly identified. This put people at risk.

For one person who had been identified as at risk due to weight loss, the service had concluded that the weekly monitoring of their weight would assist in the assessment of their health. However, this had not been completed by the service on a weekly basis and therefore did not adequately manage the risk. Other people who the service had assessed as needing their weight monitored on a weekly basis to mitigate similar risks, had not been weighed at all in April 2017. Another person who used the service had been consistently losing weight. However, we saw that they were still being weighed monthly which meant their weight loss was not being monitored effectively and the associated risks fully mitigated.

These concerns constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Procedures were in place to help protect people from the risk of abuse. However, these were not always followed by staff and some staff may not have been aware of them. This was because, at the time of our inspection, only 45% of staff had received up to date training in safeguarding vulnerable adults. From the information we hold about the service, and from discussions with the service managers, we determined that staff had not always reported incidents as procedures required. One of the service managers told us that they were aware staff often 'normalised' behaviour and symptoms that could indicate potential abuse. There were also occasions where there had been a delay in staff reporting concerns to the service managers. Subsequently this had meant a delay in the service reporting these incidents to us, as required by law and to the local authority safeguarding team. This put people at risk and did not ensure people were fully protected.

These concerns constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We brought the non-availability of people's medicines to the attention of one of the service managers who acknowledged these concerns. They told us that the lack of medicine stock had been as a result of a change in how the GP surgery processed prescriptions. The service manager told us this had caused delays in prescriptions being authorised and therefore received in the home. They told us that they would raise this with the local Clinical Commissioning Group and GP practice manager to ensure safeguards were in place to prevent it happening again.

We looked at how information in medication administration record (MAR) charts and care notes supported the safe handling of people's medicines.

The medicines management in both Birch and Bluebell demonstrated that people had received their medicines as prescribed and that good practice guidance had been followed. However, the MAR charts we looked at for those people living in Holly Court did not demonstrate that medicines had been managed in a consistently safe manner. Where people had been prescribed medicines on an 'as required' basis, guidance was not always in place to ensure staff administered these safely and appropriately. In addition, the temperature of the fridge where certain medicines were stored was recorded on a daily basis but there were substantial gaps in these records. This meant the service could not be sure that medicines were being stored at the correct temperatures. There was, therefore, the risk that the effectiveness of some medicines was being undermined.

Staff demonstrated through discussion that they knew the risks to those they supported. However, care plans did not consistently demonstrate these risks and anomalies were found across these records. For example, one person's transferring procedure had been assessed as too high risk and, as a result, they were required to be supported in bed at all times. However, their care plan did not consistently record this and

some sections showed this person as still being able to transfer with the use of equipment. This put the person at risk of receiving unsafe care and support, particularly as the provider was using agency staff, some of whom may not have worked at the service before.

In addition, notes made in preparation for the handover to the next shift were brief. Further, staff told us that handovers could be problematic as shifts did not allow for any overlap of staff between shifts. Staff told us that they were expected to arrive early for their shift or stay after their shift had finished in order to receive handover information. Staff told us that this did not always happen. For example, where changes had been made to the support one person required following a hospital stay, we saw that this was included in the handover communications book. However, on one of our inspection visits a staff member had failed to read this which put the person at risk of receiving inappropriate and potentially unsafe care.

We asked people if there were enough staff on shift to assist and support them as required. Most thought there were, however one person told us, "Staff don't interact enough.' They went on to say, "The way staff treat me is fine but they concentrate only on things like immediate concerns.' Staff views on the level of staffing differed. Whilst most felt it was adequate, one told us they did not have enough time to meet people's needs above those that were basic. This staff member said, "The staff you have got are constantly running around doing personal care side of it and haven't got the time to interact with people." When we asked a service manager how staffing levels were assessed, they told us this was dictated by contracts in place with the health service. However, not all people who used the service had these contracts in place. When we questioned this, the service manager told us that, in these instances, the staffing levels were indicated by the provider. The service manager confirmed that no formal assessment tools were in place.

During our inspection visits, we saw that staff worked hard and appeared busy throughout the day. The service operated on 12 hour shifts and staff told us this worked well. This structure minimised the amount of change for people who used the service and helped to promote continuity of care. Staff had planned breaks but we saw that they did not always have the opportunity to take these in private or away from the communal areas of the home. This was due to the level of supervision the people who used the service required. This meant staff were not getting a proper break and some staff were too busy to speak with us. We saw that the service used agency staff to help fill gaps in the rota and ensure a consistent staffing level. Permanent staff told us that this did not always enhance the service people received. They told us this was because different agency staff were sent who were not familiar with people's needs. One person who used the service agreed with this and told us they felt like an 'experiment' when staff supported them who didn't know what they were doing.

The risks associated with the premises had been identified, assessed, managed and reviewed on a regular basis. Regular maintenance checks had taken place to further mitigate risk. This included the regular servicing of equipment, the monitoring of the firefighting systems and checks completed to reduce the risk of Legionella bacteria within the water system. The provider also had a business continuity plan in place in the event of an adverse incident, or disruption to, parts of the service such as IT systems, catering provision, utility failure or severe weather.

During our inspection we saw that a number of lights in people's rooms were not working. Staff told us they got a slow response to maintenance issues. One staff member told us that, due to the slow response to maintenance issues, staff often rectified minor maintenance issues themselves rather than wait for the maintenance team to respond. This staff member told us this was in order to reduce the impact on those using the service. Staff told us the slow response was due to the quantity of work the maintenance team had to complete which included maintaining all units on the premises, maintaining the grounds and completing regular health and safety checks.

The provider had processes in place to reduce the risk of employing staff not suitable to work in the service. This included the completion of background checks and an interview by two members of senior staff. The staff recruitment files we checked, confirmed this to be the case.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called 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.

There was confusion across all units of the service in relation to MCA and records did not consistently show that the service was fully adhering to the MCA. For example, a number of applications had been made for consideration to deprive people of their liberty in order to keep them safe. In Holly Court, there was no documentation to show that these people's capacity to make a decision in relation to the restrictions in place had been assessed.

For Bluebell and Birch, whilst people's capacity to make decisions had been assessed, records did not fully demonstrate that the MCA had been followed. For example, records contained little rationale for decisions made during the assessments and did not demonstrate that all practical and appropriate steps had been taken to assist the person in making their own decision. Records did not consistently show that appropriate people had been consulted when making best interests decisions.

In Bluebell, we saw that appropriate health professionals had been involved in making a best interests decision for a person receiving their medicines covertly (hidden in their food and given without consent in place) and that this was recorded appropriately. However, this decision had not been reviewed since the decision was made in May 2015. The MCA states that decisions made in people's best interests should be reviewed on a regular basis.

For another person living in Bluebell, a DoLS authorisation had expired and the service had overlooked the need to reassess and make a further application if deemed necessary. This meant that the current decisions made in relation to this person may have been made unlawfully. When we brought this to the attention of a service manager, they told us this had been an oversight.

For a third person living in Bluebell, the service had made a decision to restrict the person's liberty without full adherence to the MCA. The person's capacity to make the associated decision had not been assessed and there were no records to show that a best interests decision had been made, by whom and when.

These concerns constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

During our inspection in 2016, we found that staff were not always properly trained to meet the specific needs of the people they were supporting. The management team were aware of this and told us that they were addressing this issue.

However, during this inspection carried out in April 2017, we found continued and significant gaps in the training the provider considered as their core training areas. For example, just over a half of staff had completed core training in dignity and person centred approaches. This percentage had declined since our last inspection. Further, less than half of the staff had completed training in human rights, health and safety and infection prevention and control. Only nine staff out of the 96 employed had completed training in effective communication. One fifth of staff had undergone training in positive behaviour support and working with behaviour that challenges others.

Those staff employed in a clinical role had not had their competency to practice in specialised areas assessed or reviewed. Further, we saw that no nurses had received training in wound care with only one having received training in tissue viability. Three nurses had been trained in catheterisation. The provider considered these training topics as mandatory for these roles and this service. In total, the service employed 10 nurses.

The lack of up to date training and assessment of clinical competencies increased the risk that people could receive care and support that was not in accordance with best practice. The provider had failed to ensure there were sufficient numbers of suitably competent and skilled persons to meet people's needs.

These concerns constituted a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection carried out in March and April 2016, we found that the service could not demonstrate that people always received enough to eat and drink to ensure their health and wellbeing. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection in 2016, an action plan was submitted by the provider which detailed how the service would meet their legal requirements. They told us that these actions would be completed by 1 June 2016. At this inspection, carried out on 19 and 20 April 2017, we found that although further improvements were required, the provider was no longer in breach of this regulation.

The people who used the service gave us mixed views on the food provision within the home. Some people were happy with it and we received comments such as, "You get a good meal", "The food is always good" and "The food is very good." However, others disagreed. One person said, "The food is all right". Another person told us, "The food here is reasonable". A third person said, "I had sandwiches for lunch, you get too many sandwiches to be honest."

During our inspection we saw that people had choice in where they took their lunch with some opting to stay in their rooms with others having lunch in the dining room across all three units. People received assistance as required although in Holly Court we noted one staff member standing while assisting a person to eat their meal. This did not promote a relaxed and dignified meal time experience for the person. We also noted, in this unit, that a menu was displayed but that the options offered for lunch did not coincide with the menu on display. However, the people who used the service told us that they had choice in the food and drink they received.

We viewed the staff training information in relation to meeting people's nutritional needs. The provider told us that they considered nutritional wellbeing training to be mandatory for all care staff. However, records showed that only 45% of staff had undertaken this training. This amounted to 40 support workers, nine nurses, one team leader and one service manager.

Staff told us that they had received an induction and were supported on a regular basis by supervisions and appraisals. Service managers told us that performance, procedures and service related topics were discussed at supervisions. We also saw from minutes of staff meetings that discussions took place in regards to topics associated with providing a service.

People told us they saw healthcare professionals on a regular basis and the staff we spoke with agreed. One person told us they saw the chiropodist regularly and that staff supported them to access the GP and dentist. Another person who used the service told us they trusted staff to arrange hospital treatment for them should this become necessary. Staff told us people's healthcare needs were met in collaboration with other health and social care professionals and we saw this to be the case from the records we viewed.

Requires Improvement

Is the service caring?

Our findings

The people who used the service told us that staff treated them well and helped them with their day to day lives. One person said, "I'm pleased to be here, [staff] help me a lot and get me things." Another person told us, "It's been a good time for me, the girls [staff] are lovely and very helpful." Other people made comments such as, "They [staff] look after us, anything we want, they do" and, "It's lovely here, they [staff] do everything for you…The carers are good, it's marvellous."

We observed positive staff interaction throughout the home. We saw that staff were mostly respectful, polite and caring. However, interactions were often brief and made in order to respond to people's distress. We did, however, observe two staff members on Bluebell ignore a person when they knocked on the door to the care office. This happened on two occasions. However, we also saw examples of warm and reassuring interaction between staff and those living in Bluebell. For example, we saw one staff member offering encouragement and comfort to a person who had become upset.

In Holly Court, staff engaged with some people regularly, although this was often brief because of a number of people requiring reassurance. Staff tried to support people with high levels of anxiety and when getting distressed tried to divert their attention or offer an alternative activity such as a walk. However, this was not always successful and we saw that staff attention was often focused around one individual meaning other people didn't receive the engagement they wished for. One person who used the service told us, "I get lonely, staff don't come and talk to me." Another person said, "Staff are more or less here to make sure things run okay, although we are individuals, we are treated like a block."

One staff member we spoke with gave examples of the caring nature of their colleagues on Bluebell. They told us one staff member, after supporting a person using the service to choose an item of clothing online, used their own time to purchase it for them. They explained that the person did not like going shopping themselves. The staff member said of their colleagues, "They go out of their way."

People were minimally involved in the care, support and treatment they received although staff gained consent before assisting them. One person who used the service said, "I presume I must have a care plan, what it entails, I have no idea, I've never seen it." The relatives spoken with said there was not much communication about what was happening at the service and any changes. They were not aware of a newsletter, recent care plan reviews or relative meetings. They did, however, say staff informed them of any changes in their family member's health and well-being.

A service manager told us that they had recently changed the time of day when the main meal was served. This was now served late afternoon rather than lunchtime. The service manager told us this was to ensure those that liked to sleep in in the mornings didn't miss their main meal. However, we saw no evidence that those using the service had been consulted in regards to this.

We asked to see minutes from meetings held with those who used the service to see whether they had been involved in the delivery of the service and decisions around this. We were only supplied with minutes from a

meeting that had taken place in January 2017 and on only two of the three units. There was no further evidence to show that people had been consulted in how the service was delivered or asked for their suggestions or views.

People told us they were offered choices in their day to day routines but this was not recorded in people's plan of care. We saw staff offering a choice of meal and fluids but choices around activities were restrictive. One person was asked more than five times if they wanted a walk in the grounds but we observed little else in terms of planned activity. The television was on but people were not watching it and some people had sensory issues which would impact on their ability to do so.

People's independence was supported in regards to their personal care and people told us staff supported them with this. However, care plans did not always reflect their preferences in how they wished to spend their time and often spoke about people in the past tense. For example, what people used to do rather than what they could do and wanted to do in the future. Of the care plans we viewed, we saw no records to show that people's aspirations or goals were recorded or supported. People's dignity was mostly maintained and except for hearing a staff member refer to people as room numbers, we saw support that maintained this. People's confidentiality and privacy were maintained and this was evidenced well within the service. For example, staff discussed people's care privately and people's confidential records were secure at all times. Staff spoke respectfully and warmly about those they supported. Most of the staff we spoke with knew those that used the service well.

Requires Improvement

Is the service responsive?

Our findings

People's basic care needs were met but they did not receive a person centred service, particularly when it came to their interests and hobbies. One person who used the service told us, "They [staff] make sure you are okay but nothing else. The staff know what they're doing but my needs are not met." They went on to say, "I feel confined." Another person said, "I sit about all day, they have things [activities] but they don't interest me."

The care plans across all three units of the home varied in terms of the amount of information recorded and how accurately they reflected people's needs. Initial assessments of people's needs did not give very much information. Some people had a one page profile which would help staff unfamiliar with the person see at a glance how to support them. There was also a care plan for each area of need. However, these often lacked person centred information to assist staff in supporting people on an individual basis. Care plans were reviewed monthly but we saw instances where they had not identified change in needs or shown how staff were to address this. A family member we spoke with said they were not regularly asked to contribute to their relative's care plan despite visiting frequently.

We looked in depth at most of the nine care plans we viewed. They were large and unwieldy and information could not be found easily. We were unable to see how some issues had been followed through. For example, a person had had a blood test in January 2017 that had been recorded in their care plan. However, no further records were available to explain the outcome of the test and potential impact on the person. The nurse in charge told us that they assumed the result was okay but could not find any records to demonstrate this.

People's care plans did not consistently provide staff with enough information to support people and ensure their wellbeing. For example, for one person who was living with diabetes, their care plan instructed staff to encourage the person to make healthy food choices. However no further information was available in regards to how to do this, what foods were healthy or any information to show the person had been involved in their care plan. It did not show what foods the person enjoyed, liked or disliked.

Care plans had been reviewed however they did not fully demonstrate how the person, or their family members if appropriate, had been involved in this. The relatives of one person we spoke with told us that they had been involved in one review in 18 months. Other care plans indicated people did not always wish to participate in a review of their needs and it was not clear how staff tried to effectively engage people or if people's needs were regularly reviewed with the involvement of the funding authorities and outside professionals. Some reviews were documented but not with the degree of frequency agreed.

Supporting people with behaviours which negatively impacted on them or others were poorly recorded in most cases. People's care plans did not give much detail or guidance for staff about how to support people with complex needs and high levels of anxiety. Care plans did not include clear strategies to ensure staff were working consistently. We observed a person's anxiety escalate throughout the day and staff struggling to support them with this. A number of people spoken with told us they did not like to use the lounge

because of the noise and behaviour of others.

Staff told us they completed observation charts which included information on people's behaviour, possible triggers and consequences to the behaviour. However, we reviewed some daily notes which showed one person being administered medication to help reduce anxiety but without giving any additional information about other strategies used to try and calm the person and whether these were effective or not. The daily notes did not refer to whether an observation chart had been completed or included any information enabling us to evaluate the effectiveness of the strategy or the actions taken.

Staff opinion varied on whether they felt able to be responsive to people's needs in a person centred manner. One staff member told us this was achieved when they were fully staffed with permanent staff. However, another staff member told us, "There's not enough staff for everything they [provider] want us to achieve. If they want us to give a good quality of life [to people] and get them out then there's not enough staff." Another staff member told us that they would not recommend the service. They told us this was because of the lack of continuity of care.

Care plans did not include personal goals or achievements and the majority of people we spoke with told us that they didn't have enough to do. One person who used the service said, "All day I do nothing." Another told us, "I walk about, sit here and think." They went on to say how a hobby they used to participate in allowed them to, "Express themselves." They said, "It's the boredom, I'm solitary by nature but in [local town] I had friends." A third person said, "I like reading, watching telly, things like that. I don't really know what I do from one day to the next." However, another person spoken with told us they were taken out in the car each week and had a key worker to help them with things.

We spoke with two relatives of one person. We asked them about how the service provided sufficient stimulation for their family member. They had concerns that this did not happen outside their regular visits. They told us that their family member had had many interests before living in the home but that they now felt they were no longer supported to participate in these hobbies and interests.

One staff member told us about how difficult it was to support people to engage in the local community. They told us this was due to lack of available transport and last minute changes to staff rotas. They told us that outings were difficult to arrange as rotas were made available at such short notice. The staff member said last minute changes to staffing also contributed to the difficulties in arranging outings for people outside of the service. The staff member told us they felt the people who used the service would be more motivated and more inclined to engage with others if weekly trips could take place. Another staff member told us there was not always enough staff or drivers to assist people with trips out. A third said people did not always want to 'join in,' whilst a fourth staff member told us, "We provide activity when we have 10-15 minutes."

During our inspection we observed little activity and stimulation. An outside entertainer was present during the morning of one of our visits who made their way around each unit. Brief interactions were also seen to take place between staff and those using the service. We also noted that a staff member informed one person who used the service that they would support them on a social visit that afternoon. We saw that the person wished to participate in this and we saw that this staff member promised this on more than one occasion. However, the trip never happened. Throughout our inspection we saw that this person sought staff interaction consistently throughout the day but that staff did not engage in any meaningful interaction with them.

The care plans we viewed stated the interests and hobbies people had in the past but failed to provide

information on people's wishes and the support they required to fulfil them. A record indicated what people used to like to do and what they did not; this was a tick list and gave no scope for meaningful discussion around leisure and social interests. There was no evidence from people's daily notes of how this was used to plan activities around the person's individual needs. We saw that activities were not centred on people's genuine interests, hobbies and life experiences. For one person, their records stated that they chose to spend a lot of time in their bedroom. However, there was no guidance for staff about how best to provide support to this person in order to prevent social isolation.

We looked at people's activity records and daily notes; these confirmed that activity was limited. Some days nothing was recorded other than assistance with personal care. On other days visits from family were documented. Staff confirmed some people had no family and was little engagement from community groups or volunteers. One person had a weekly visit from MIND. From the notes of another person, we saw that they had received no activity engagement since March 2017.

These concerns constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One of the service managers told us there was a budget of 40 hours a week for activities but the person deployed for activities had recently left. They said staff were paid overtime to continue to provide activity for people. However, we saw that little activity or social interaction took place and staff told us this did not consistently happen.

The service had procedures in place to manage any complaints people may have. We saw that the complaints policy was visible within the home. The service had not received any complaints since our last inspection.

Inadequate

Is the service well-led?

Our findings

Systems to assess, monitor and improve the quality and safety of the service had not been fully effective at identifying concerns and rectifying them in a timely manner. Records were not consistently accurate, complete or contemporaneous in respect of each service user. The provider had an auditing system in place however the associated procedures had not been regularly and consistently applied at the service. In addition, those audits that were in place did not fully mitigate the risk of continuing concerns.

We were told by a service manager that the care plans for all people living in the home had been audited. Further, we were told that the provider's procedures instruct that five care plans are to be audited on each of the three units every month. The service manager told us that copies of these audits were in the front of each individual's care plan. We asked for the audits of care plans for four named individuals. The service manager could not produce these audits nor provide us with any other completed care plan audits. We did not see a care plan audit in the front of any of the nine care plans we viewed during the inspection.

We saw from the provider's quality report following a visit in January 2017 that they had also identified concerns with care plans and meeting people's needs in a person centred manner. The report stated that care plans and risk assessments did not reflect people's needs and the lack of clear information on how risks were being mitigated. Further, it identified gaps in records and a lack of guidance in relation to supporting people to remain well. It concluded that people were at risk of receiving inappropriate care and that individual needs were not being adequately met. The service had an improvement plan in place. This showed that all care plans and risk assessments were to be updated and accurately reflect people's needs by 13 March 2017. This hadn't happened and concerns were still present at this inspection as highlighted in this report.

We were told that the medicines management arrangements in each unit were audited on a regular basis. We requested the last three medicines audits that had taken place on each unit. Shortly after our inspection, a service manager emailed us to tell us these could not be found and that they were unable to provide them.

A medicines management audit for the whole service had taken place in early April 2017 as part of the provider's routine checks. However, this hadn't been fully completed and although it instructed staff to score points for each section in order to gain an overview of the quality of medicines management in the service, this had been left blank. In addition, it did not indicate which person's medicines had been audited meaning rectifying any anomalies would be difficult to achieve. This audit had identified a few issues. However, although there was an action plan section, this had been left blank and did not record the actions required to rectify the concerns found or who was responsible for ensuring these took place.

In January 2017, senior management had identified that staff had not completed training as required and that overall 55% of staff training had not been completed. They also noted that the practice of clinical staff was not being assessed. Further, they identified that the service managers had completed little of their core training. They concluded that this showed the workforce was not skilled to provide the care and awareness

needed to support the people who lived in the home. At this inspection, we noted that the practice of clinical staff was still not being assessed and that the training compliance rate for staff was still low at 50%.

The provider had identified issues around meeting people's nutritional needs in January 2017. The senior management quality report for this time showed that some people were not being weighed as they should be in relation to the risk. The service improvement plan also showed that the service was required to ensure clear recording was in place in regards to meeting people's nutritional needs. It stated that clear rationale for the use of food and fluid charts needed to be recorded. An update to this plan made on 7 February 2017 showed that issues around recording were still an issue. These concerns were still evident at this inspection.

A number of quality monitoring tools used by the provider showed that the social and leisure provision was not adequate yet these concerns were still present at this inspection. The senior management's quality report for January 2017 showed that the quality of people's activity plans was very poor and that they showed no involvement from the people who used the service. It noted that during their visit they saw little interaction between staff and those that lived in two of the three units of the home. The service manager's audits for January, February and March 2017 all showed that no person using the service was engaged in any paid or voluntary work, attended any type of day service or was a member of any local amenities outside of the service.

In addition, the provider asked people who either used, or had experience of, another of their services to attend Swanton House Care Centre in order to complete a quality review. This visit was called a 'quality expert observation' visit. One had been completed on 15 March 2017. The subsequent report recorded that it was unclear as to whether people were engaging in activities or indeed that they wanted to. It also reported that the author of the report would, "Be bored living at Swanton because every day seems to be very similar which is the same as the previous two visits." The author concluded that it was sad to think that the only thing people had to look forward to was a cup of tea.

Some issues had also been identified by the provider in relation to staff compliance with the local authority's safeguarding policy and the MCA. The monthly service audits completed by a service manager in January, February and March 2017 all showed that they could evidence that only a quarter of all staff had read the local authority's safeguarding policy. The senior management's quality report for January 2017 showed that they had identified that DoLS authorisations had expired across all three units of the home. It also acknowledged that no further applications had been made or best interests meetings completed as required.

Whilst the provider had identified a number of concerns as highlighted in this report, required improvements had not been made in an adequate timeframe and issues were still present. This demonstrated that the quality monitoring system the provider had in place had not been effective at driving improvements. Further, there was a lack of effective management and oversight to ensure that the necessary improvements in quality were made.

These concerns constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management team at Swanton House Care Centre had seen a number of changes since our last inspection in 2016 and this had adversely impacted on the service. We were told that all three units should have had service managers in place. However, at the time of our inspection, there were only two in post. The three units appeared to work differently to each other and this did not aid continuity or help drive consistent improvement.

It was not clear who had overall responsibility for the management of the whole service and this caused confusion. At the time of the inspection an application had been received by CQC to register one of the service managers. However, shortly after our inspection, we were told this was due to be withdrawn. In addition, the two service managers were not completely clear on their responsibilities and accountabilities within the service. One staff member told us, "We need to know who's in charge and who we should go to."

It was clear that there were not enough management resources in place to ensure a safe, consistent and good quality service was delivered. One service manager explained how they were just dealing with priorities and had no time to manage the backlog of work they said the service had. They told us they were, "Papering over the cracks" and simply didn't have time to work on, "The areas to be fixed." Whilst they told us that the provider was supportive and present, they felt their expectations were unrealistic. They did, however, state the provider was, "Very focused on the service" in order to make the improvements needed.

However, all the staff told us that they found the service managers and senior management team supportive and approachable. They understood the managers were under pressure and busy and were empathetic of this. This demonstrated, along with observations and discussions with staff, that, even though the service was facing difficulties, the culture was a positive and supportive one. Staff morale varied across the units as did team work but all were supportive of their colleagues and we saw that staff were committed. One staff member said of a service manager, "They've got my support and my respect." Staff spoken with felt able to raise concerns with any of the management team.

Staff expressed concerns over the instability of the management team and the amount of changes that had taken place with each new manager. They told us changes were made without consultation. One staff member told us that they thought morale was low and that staff were frustrated due to the changes. They said, "One minute we have to do things this way, six weeks later, it's changed." Another staff member said that morale was, "Not brilliant. Mainly due to staffing or management being unavailable as they're trying to do so much."

We couldn't see how the service had gained feedback from those that used the service. The hospitality services lead told us that they had recently sent out a questionnaire on the food provision and we saw that a meeting was held in January 2017 for some of those that used the service. However, we saw no other ways in which the people who used the service could contribute ideas and suggestions. No formal feedback had been gained from staff although they told us that they had regular meetings. We did see from the minutes of one of these that staff views were sought.

The relatives and friends of those that used the service had last been sent questionnaires in 2016 and the results had been analysed in August 2016. The analysis was from a provider perspective. However, the analysis that we were sent did not specify the feedback received at service level other than whether people would recommend the service so it was difficult to analyse the results in relation to Swanton House Care Centre. We did see that out of the nine people who responded in relation to this question, seven would recommend the service whilst two would not.

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 People did not always receive care and treatment that was personalised specifically for them. Regulation 9(1)(2)(3)(a)(b)(c)(d) and (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent was not always in place before care and treatment was provided. Regulation 11(1)(2)(3)(4) and (5)

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 service had failed to do all that was reasonably practicable to mitigate risks to service users Regulation 12(1)(2)(a)(b)(f) and (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes to prevent abuse of service users were not fully effective.

Regulation 13(1)(2) and (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The service had failed to implement effective systems to assess, monitor and improve the quality of the service. The service had failed to maintain an accurate, complete and contemporaneous record in respect of each person who used the service. Regulation 17(1)(2)(a)(b)(c)(e) and (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough sufficiently competent and skilled persons deployed to meet people's needs. Regulation 18(1) and (2)(a)