Flightcare Limited

Swansea Terrace

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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Swansea Terrace provides accommodation and personal care, including nursing care for up to 44 people in single bedrooms with partial ensuite facilities. Rooms are on the ground and first floor. There are two lifts and stairs for access. Communal areas are on the ground floor. There was a paved area at the rear with some seating for people to access. At the time of inspection there were 36 people in the home,

People's experience of using this service and what we found
People had not always received safe care because assessed risks had not been consistently managed. Alerts on the care records system which indicated people had missed support with repositioning or had not had enough to drink, had not been responded to in all of the cases we reviewed.

People had not received their medicines safely. Diabetes care was inconsistent and not enough information was available to guide staff to recognise increased risks related to blood sugar levels. Medicine stocks were not properly monitored which meant some people did not always have enough. Oversight of medicine records had not been safely maintained by managers.

People had not been supported to drink enough. Everyone assessed as needing support to drink had missed their fluid targets. Some people felt they did not get enough of the right foods in relation to their dietary wishes. We observed people enjoyed the food they were served at lunch times.

People were supported by staff who had been safely recruited. The provider followed a system to assess how many staff were needed to maintain people's care safely, however, we found staff were not able to meet all of people's needs.

People's needs had been assessed using an electronic system. Staff accessed care records on handsets. Some assessments and care plans did not contain enough information to guide staff.

People's health needs had been assessed, however we found some records had not always been updated. People had access to health screening, including a visiting optician.

People did not receive consistent high-quality person-centred care because managers had not ensured there was enough oversight of the quality of care and care records. Recent changes to the management structure in the home had impacted on this. The provider and interim manager were committed to working with partners and following their own action plan to achieve the necessary improvements.

People and their relatives had mixed views about how well the home was managed. The home's regular staff were praised as being knowledgeable and caring. People's relatives did not feel they had been asked for their feedback recently however, this was an area the provider had already identified as needing to be addressed.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Why we inspected
The inspection was prompted in part due to concerns received about the availability of registered nurses on each shift, the quality of clinical care in relation to; safe medicine administration, wound care and access to community health services. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The provider had already begun responding to some of these concerns and had developed their own action plan.

The overall rating for the service has changed from good to requires improvement, based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe, effective and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
We have identified breaches in relation to; the management of risks, safe management of medicines, supporting people to eat and drink enough, management oversight and governance. We have made a recommendation about care assessments and planning.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The home was not always safe Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led Details are in our well-led findings below.	**Requires Improvement**

Swansea Terrace

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was completed by an inspector, a pharmacy inspector, a nurse specialist advisor and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. One Expert spoke with people on site and their visitors and another made calls to relatives.

Swansea Terrace is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Swansea Terrace is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. There was a manager in post who had applied to register. However they were off at the time of inspection and therefore, there was an interim manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We received feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We reviewed the the care records of 14 people and multiple medicine records. We spoke with 14 people who lived in the home and the relatives of 12 people. We spoke with three senior managers, the interim manager and 12 staff including; nurses, care staff, housekeeping staff and the office administrator. We looked at a range of maintenance and premises safety records including fire risk assessments and safety equipment checks. We observed lunch on 2 days and looked around the building including some bedrooms.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- Some people had not received their medicines as prescribed. Some medicines were not always in stock. Medicine records did not provide accurate information about stocks because balances had not been transferred to new medicine administration records, (MAR) each month.
- Diabetes care was inconsistent. Care plans to support people with diabetes lacked sufficient detail and were not person centred. One person's insulin regime was incorrect. The provider began to respond to this during the inspection to develop effective diabetic care plans.
- Information to guide staff when to give medicines prescribed 'when required' including pain relief, inhalers and sprays for angina, were not in place. People were at risk of not receiving these medicines properly.
- Monitoring of medicines by managers had not identified staff were not following the provider's medicine policies or the issues we found during the inspection.

Medicines were not managed safely. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- People had not been supported to manage the risks in relation to repositioning. We found staff had recorded repositioning for several people who had not been repositioned.
- Staff were prompted on an electronic handset to meet people's assessed needs staff recorded when they had completed these. Where any care interventions had been missed, an alert was generated. Overdue alerts had built up and had not been responded to. We were not assured the missed activities had been responded to or picked up by managers.
- Risk assessments and risk management plans had not been completed or not completed in sufficient detail to minimise the risks in relation to equipment including bed rails.
- Eighteen people were cared for in bed, it was not clear from risk assessments who needed help to sit out. Staff told us they did not have enough time to support people to get up. One person living in the home told us they don't bother getting up and going downstairs because it takes too long to get help to go back to their room.

Risks were not always managed safely. This placed people at risk of harm. This was breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Maintenance of the home, safety checks and procedures in relation to legionella, fire safety, electrical safety and gas safety were up to date. Where tasks had been identified by contractors, the provider had

ensured these had been followed up in a timely manner.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
●The provider had policies and procedures in place to help protect people from the risk of abuse. These were understood by staff.
● Safeguarding concerns had been raised by the provider with the local authority and CQC when they had been identified. CQC have raised some safeguarding concerns with the local authority, based on our findings at this inspection.
●Relatives feedback about how safe their family members were was mixed. Most relatives we spoke with were confident people were safe. Comments included; "Yes he is safe, the doors are all secure. We haven't had any signs of abuse. [Name] visits every day." and "Yes she is safe, they take good care of her and keep checking on her". However some relatives told us, "I don't feel she is particularly safe. On more than one occasion they don't leave the call bell in reach and she has no way of getting help."
●The provider had procedures in place to learn lessons from incidents and accidents. We found these had not always been followed by managers. Opportunities to learn lessons had been missed. We have addressed this in the Well-Led domain of this report.

Staffing and recruitment
●The provider had robust recruitment procedures in place which helped ensure staff employed were suitable to work with people. Recruitment records we reviewed included all necessary pre-employment checks.
●Staffing numbers had been determined based on the providers procedure for assessing people's individual needs. There were mixed views about staffing levels. Some staff felt they did not have enough time to support people properly. Some relatives felt there were enough staff but some relatives felt there were not, and their family member had to wait longer for support. We raised this with the provider who are keeping this under review.
●There were a high number of agency staff working in the home, including nurses. The provider was recruiting to permanent positions in the home and this was ongoing.

Preventing and controlling infection
●The home was clean and tidy. Relatives told us they found the home was always well kept. Comments included; "The home is clean. They clean his room." and "When you visit my Mum's room is cleaned every day." And "His bedroom is always lovely and tidy."
●The provider had policies and procedures in place to minimise the risk of infection and these were understood and followed by staff.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

- People were at risk of dehydration. Fluid targets assessed as needed had not been achieved for any person whose record we reviewed. Staff had not offered drinks often enough. One relative told us they visit their family member every day to ensure they have enough to drink. Staff told us they sometimes did not have enough time to offer drinks. We raised this with the provider who began to address this during the inspection.
- Following concerns and input from other agencies there had been an increased effort to identify people who were nutritionally at risk. This resulted in 9 people being referred to the dietician.
- People's nutritional needs had been assessed. The descriptors used to describe food textures was inconsistent. The handover record showed the current recommended descriptors were used, but the kitchen staff followed different ones.
- People with specific dietary needs, including vegetarian and vegan, did not have options on the menu. It was not clear how their nutritional needs were met. One person living in the home said they did not believe they got enough protein. Another person said they hardly ever had fresh fruit. We raised this with the provider who are reviewing menus with involvement from people living in the home.

People had not been supported to maintain adequate nutrition and hydration. This meant they were at risk of harm. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care

- People's needs had been assessed and care plans developed. These were accessible to staff electronically on handsets. We found some care records were not fully completed. Some care records needed more detail. We were assured this was being addressed by the interim manager.
- Information from other professionals had been included in some care records and plans of care. However, we found it difficult to access copies of letters from other professionals and were not assured their advice had been accurately included in care plans.

We recommend the care record and care planning system is reviewed to ensure people have up to date assessments and care plans.

Staff support: induction, training, skills and experience

●The provider had induction training programmes for staff and agency staff which helped ensure they were familiar with their roles and the organisation.
●Mandatory and additional online training was completed by staff. There were some gaps in the training matrix which the provider was following up with staff.
●Staff told us they had enough training and skills to know how to support people effectively. Feedback from relatives was mixed. Some relatives praised the staff team in the home but felt some agency staff did not know enough about their family member to support them effectively. The provider was aware of this and was proactively working to ensure regular agency staff were employed and to ensure the home were fully staffed as soon as possible.

Supporting people to live healthier lives, access healthcare services and support
●People's health needs, diagnoses and treatment plans had been included in assessments. However, we found they had not always been updated in response to changes.
●People living in the home had access to health screening. An optician had visited recently and several people had new glasses.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.
●We found people were not deprived of their liberty without appropriate legal authorisation either applied for or in place.
●Care records included some mental capacity assessments in relation to some particular decisions people needed to make, this included receiving personal care, support with medicines and living in the home. The management team were in the process of reviewing these to ensure they were up to date.
●Staff we spoke with understood the importance of gaining consent from people before providing personal care.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider had systems in place to oversee the quality of care, care records and the premises. We found these had not always been followed by managers. Oversight of missed care interventions, missed fluid targets and incomplete risk management records had not been identified by audits.
- There were handover meetings twice a day to inform staff of any changes and identify their tasks for the day. We found these could have been used better to direct staff to support people to drink more.
- Staff were aware of their roles and responsibilities. Some staff felt they were not able to complete all of their tasks due to staffing levels. One relative told us, "I couldn't recommend this home because there are too many inconsistencies."
- People had not always received person centred care which reflected their individual needs and preferences. People had not always been empowered to maintain important lifestyle choices or to be as independent as possible.

Oversight of the quality of care provided and care records had not been maintained. This placed people at risk of harm and was a breach of Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider understood their obligations in relation to the duty of candour. There were policies in place to guide staff to ensure the right people were notified of incidents.
- Some relatives commented on the high turnover of staff and management in recent months which they felt contributed to a lack of consistent communication. However, one relative told us they were confident they were kept up to date with incidents affecting their family member.
- Notifications had been made to the appropriate organisations when required, this included; CQC the local authority and Health and Safety Executive.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider had a variety of systems in place to engage with people living in the home and their relations. These had not been followed consistently which meant people's views were not known or acted on in a

timely way. We raised this with the provider during the inspection who started to consult with people and seek their views.

●The majority of relatives said they had not been asked to provide feedback or attend any meetings. However, some people commented they were consulted about the use of cameras in communal areas. One relative said; "[Name] fell and they called me. Any other updates I find out when I visit."

●Staff meetings had been held and regular daily handovers supported staff to keep up to date. We found these meetings could be more effective and have raised this above.

Continuous learning and improving care; Working in partnership with others

●The provider and interim manager were open and cooperative with partners to learn and respond to concerns.

●We found the provider and interim manager responded positively to our findings and were committed to continue to follow their action plans and to achieve good quality and consistent care.

●Local authority and health colleagues feedback reflected similar positive findings.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to have effective oversight of risk management.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider failed to ensure people had enough to drink. Some food descriptors were inconsistent.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure medicines were safely managed. Information to guide staff was not available. Some people did not always have enough medicines. Diabetic care was not safe.

The enforcement action we took:

Issued warning notice in relation to medicines

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure systems to monitor the quality of care and care records were followed. This resulted in people not always receiving safe, high-quality, person-centred care

The enforcement action we took:

Issued a warning notice in relation to Governance