Ambient Support Limited

Swan House

Inspection report

High Street
Winslow
Buckinghamshire
MK18 3DR

Tel: 01296711400
Website: www.heritagecare.co.uk

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

About the service
Swan House is a residential care home providing accommodation and personal care to 10 people aged 65 and over, at the time of the inspection. The service can support up to 32 people.

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

People's experience of using this service and what we found
We found safe care and treatment was provided. People were safeguarded from risks of abuse and other risks. Safe medicines practice was followed, and people told us they received safe care. Accidents and incidents relating to people using the service were monitored to identify wider learning for the service.

People were protected from infection control risks in relation to COVID-19, although we observed some instances of poor practice. The service was responsive to our feedback. People told us staff wore personal protective equipment (PPE) to support them, and people's mental capacity had been considered in relation to regular testing for COVID-19. Relatives were able to book appointments to visit. One relative commented, "They have a separate entrance and [we go] upstairs to a room that is cleaned every time…they are very particular about cleanliness…we can phone on video calls anytime."

People told us they received safe care. Some people living with dementia were not able to tell us about their experiences of care. We observed communal areas at different times of day, including at meal times and during activities. Staff spoke warmly with people, offering choices of food and drink, and supporting people to engage in activities such as bingo. People appeared relaxed in the company of staff. Some people preferred to spend more time in their rooms. We observed rooms were personalised and one person using the service was supported to keep their cat with them.

Safe recruitment procedures were in place. People were supported by sufficient staff, including support from senior staff on each shift. A structured handover process was in place, to ensure incoming staff were aware of any current concerns or changes for the people they support. Staff told us they had access to training and regular supervision, however we found staff had not completed a yearly appraisal at the time of our inspection. We found the provider's policy required staff to complete moving and handling training on a three yearly basis, which was not in line with best practice guidance. We recommended the provider refer to best practice guidance in relation to the training topics, training frequencies and assessing staff competencies to review their approach.

The management of the service had improved, however there had been a significant delay in recruiting a new home manager since our last inspection. An interim manager had worked to support the service to make improvements, and the provider conducted audits and regular quality meetings to review progress. A

full-time manager joined the service in August 2021 and we received positive feedback from people, staff and relatives. The manager had made a positive impression and was viewed as accessible and supportive by the staff team.

Feedback from relatives also confirmed improvements had taken place. Comments from relatives included, "General feeling that staff are more confident about what they are doing", "Communication now is much better", "Staff are helpful and responsive to emails; things have changed and improved since new management", "I think it will go from strength to strength…I am very happy" and "Honestly we are happy and there is nothing I would change. They don't have a high turnover of staff so there is continuity and that's important."

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; however the policies and systems in the service did not always support this practice.

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

Rating at last inspection (and update)
The last rating for this service was inadequate (published 12 January 2021).

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found some improvements had been made, however the provider was still in breach of regulations.

This service has been in Special Measures since January 2021. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
We carried out an unannounced focused inspection of this service on 25 November 2020. Breaches of legal requirements were found in relation to safe care and treatment, safeguarding from abuse, recruitment practices, consent to care, good governance, duty of candour and in informing the Commission of incidents they are required to. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from inadequate to requires improvement. This is based on the findings at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Swan House on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We have identified breaches in relation to consent to care and duty of candour.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Swan House

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by one inspector, with remote telephone support from an Expert 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.

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

The service did not have a manager registered with the Care Quality Commission. When a manager is registered with the Care Quality Commission, they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought 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 with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
During the inspection we spoke with five people using the service, eight relatives and 15 members of staff including five care assistants, two senior care assistants, two care team leaders, the deputy manager, the activities coordinator, one chef, one housekeeper, the interim manager and the manager.

We observed infection control and medicines practices, reviewed the environment and looked at five people's records on the electronic care plan system. We also examined a variety of other records including medicine records and cleaning schedules.

After the inspection
We continued to review records shared electronically and continued to seek clarification from the provider to validate evidence found. We looked at six staff recruitment and supervision files, action plans, audits, staff rotas, safeguarding records, meeting records, policies and procedures and staff training records. We received feedback from ten professionals who had contact with the service.

Good

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to good. This meant people were safe and protected from avoidable harm.

Staffing and recruitment

At our last inspection we found systems were not robust enough for the safe recruitment of staff. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 19.

- Safe recruitment procedures were in place. Staff completed an application form, attended for interview and preemployment checks were carried out. These included disclosure and barring checks (DBS), two references from previous employers and a medical review by occupational health to confirm staff were fit to work, or identify any reasonable adjustments required. Staff files contained a recent dated photograph, proof of identification (ID) and right to work in the UK.
- Some people had been recruited by a previous provider and we identified some gaps in records. One person had completed a previous version of an application form which did not request a full work history. Another person had been employed by the service since 2013 and did not have a current DBS. This had been identified by the service who provided evidence a new DBS application was in process. An administrator had been recently appointed and files had been collected for auditing to identify historic issues with recruitment records.
- People were supported by sufficient staff. The service utilised an electronic dependency tool which reviewed peoples' needs monthly to determine a minimum safe staffing level. Staff feedback and rotas showed the service was usually staffed above the minimum level. Some staff indicated when the service operated at minimum staffing level, occasionally due to staff sickness, they had less time to meaningfully engage with people using the service. Staff told us staffing levels were well maintained and people we spoke with felt there were enough staff. People told us staff responded promptly to call bells, and one person commented, "[There's] always someone about if I need help."
- Rotas ensured an experienced member of senior staff was available as shift leader to support care assistants. We observed a staff handover where the welfare of each person using the service was discussed and daily tasks were assigned, including responsibility for cleaning high touch points as part of infection control. Care assistants told us they felt supported by senior staff. A care assistant advised, "Very kind and helpful…today [shift leader's name]…fantastic contact with them. I never hear 'no'…[they] always immediately help." We observed senior staff supporting colleagues when someone presented as unwell and when staff were experiencing difficulties supporting a person who had undressed themselves and wanted to walk in a communal area to the shared bath. The senior staff immediately went to offer assistance.

● Staff told us they had access to training and regular supervision, however we found staff had not completed a yearly appraisal at the time of our inspection. At our last inspection staff did not receive regular supervision. The interim manager explained their immediate priority had been to ensure staff were receiving regular supervision. The manager advised they had already begun exploring staff wishes around personal development and identified staff who had an interest in undertaking NVQ qualifications.
● Staff received training in areas such as safeguarding adults, moving and handling, food hygiene, health and safety, and fire safety to equip them with the skills required to deliver safe care. Some staff had recently undertaken moving and handling refresher training, however the provider's policy only required staff to complete this training on a three yearly basis, and there was no formal annual assessment of competency in relation to moving and handling skills. This was not in line with best practice guidance. The interim manager and manager explained they were qualified moving and handling trainers and offered support to staff. For example, at the time of our inspection no one required transfers using a hoist, and the service explained staff would be offered a refresher session if they needed to use this equipment.

We recommend the provider refer to best practice guidance in relation to the training topics, training frequencies and assessing staff competencies, to ensure staff have the right competence, knowledge, qualifications, skills and experience to safely carry out their roles.

Systems and processes to safeguard people from the risk of abuse

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

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 13.

● People told us they felt safe. One person commented, "[I'm] very safe…people about all the time if I want anything." Another person told us they felt generally safe but expressed concern about a person living with dementia who had entered their room, explaining, "[Person's name] comes in, don't know where he's going…won't hurt me…bit scared." The person confirmed staff responded promptly when they used their call bell. All staff we spoke with were aware of the potential risk of the person entering the wrong room, the person was regularly checked and the service had ordered a door sensor to further safeguard others. This was installed during our inspection.
● At our last inspection we found the culture of the service did not encourage the open and transparent reporting of concerns. Work had been undertaken to inform staff of whistleblowing procedures, and individual meetings were held with all staff to provide an opportunity to raise any concerns. Staff told us they now felt comfortable raising concerns. A staff member advised, "I would raise anything I thought wasn't right… I feel comfortable speaking to everyone at the office…if weren't, know I could go to [manager's name], [interim manager's name] or HR." Another staff member told us concerns were now investigated, in comparison with the approach of previous management, advising, "[Concern] was investigated fully…was dealt with fully, never seen that done before."
● People were protected from the risk of abuse or neglect. Staff feedback and records showed the service had thoroughly investigated safeguarding and whistleblowing allegations. This process considered any required actions and learning for the service to minimise risk. The service made the required alerts to the local authority and worked cooperatively with the local authority to support the completion of safeguarding enquiries.
● The provider had policies in place in relation to safeguarding and whistleblowing concerns. Staff had

received training in relation to safeguarding adults, although refresher training was overdue for some members of staff. We were satisfied staff understood signs of abuse and their responsibility to raise safeguarding concerns. The provider's safeguarding policy had been updated in response to feedback offered by CQC at the last inspection to reflect the values of person-centred safeguarding.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

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

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 12.

● Risks to people were identified and managed. Some people using the service were at risk of falls. We observed measures in place to support a person living with dementia at high risk of falls. Records showed the service had consistently sought medical advice, including input from a physiotherapist to review the person's walking aid. The person was encouraged to wear hip protectors and during our inspection an older clip-on falls sensor was replaced by a more suitable sensor mat. We observed staff responding immediately to the alarm and staff remained with the person to encourage them to use their walking aid appropriately.
● One person using the service required a soft food diet due to their limited number of teeth and cognitive issues. All staff we spoke with, including care staff, kitchen staff and the activities coordinator were aware of the person's dietary needs. The person's weight was monitored regularly and food charts were in place due to low body weight. Staff could describe the times of day the person was most likely to eat well and staff encouraged them with foods they were known to enjoy. We found some people's food and fluid charts did not always document the reason the chart was in place, however we found staff were aware of the reason and people's food and fluid intake was discussed as a mandatory daily topic at handovers.
● Some people were at risk of skin breakdown due to regular incontinence or a reluctance to consent to support with personal care. People who required assistance were offered regular support to use the toilet, and records showed staff applied cream after each episode of incontinence. One person infrequently accepted staff support with washing. Records showed when support had been offered and declined, and periodically the person enjoyed a bath. Staff confirmed there were no current concerns with the person's skin. Records showed bath temperatures were checked to ensure a safe water temperature before use.
● One person experienced episodes where they appeared to become unresponsive and sat with their eyes closed. Appropriate medical advice had been sought. The person's risk assessment included, "[Person's name] will act like he is unresponsive. [Person] will NOT be unwell at this time but just have his eyes closed with his head down." We raised concern this could be misinterpreted by staff unfamiliar with the person and could present a risk if the person became unresponsive from a genuine medical emergency. The service agreed to immediately review the risk assessment. We observed the person appearing to fall asleep and be difficult to rouse on two occasions. Staff responded appropriately on both occasions and we observed care assistants seeking support from senior staff to check the person's welfare.
● A manager reviewed all accidents and incidents monthly to identify learning and consider any trends which could be used to mitigate risks to people. The service utilised a telemedicine system which enabled staff to seek medical advice 24 hours a day. Staff understood their responsibility to report incidents of concern and electronic care plans could be immediately updated with any changes, such as a change of medication or recent fall. A senior care assistant described how they would respond to an incident such as a fall, advising, "Full body check…make comfortable...phone through, even if just had a slip would speak to a nurse…if injured immediately would call 999." The member of staff explained they would update the

person's falls risk assessment, notify next of kin, update staff at handover and if concerned would seek GP advice.
● The service had identified potential issues with the roof space meeting fire regulations. However, contractors were appointed to rectify this and we observed work taking place. In the meantime, a recent fire drill had taken place and people had personal emergency evacuation plans (PEEPs) in place.
● At our last inspection a legionella report completed 31 October 2019 recommended several immediate actions to ensure safe water management. At this inspection we were advised the provider had independently contracted the necessary works, and we observed dead leg pipes had been removed. Records also showed regular water checks were undertaken, including the monitoring of hot and cold water temperatures and servicing of thermostatic mixing valves, which blend hot and cold water to a temperature which mitigates scald risk.

Using medicines safely

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

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 12.

● Safe medicines practices were promoted. We reviewed processes in place for the ordering, reconciliation, storage, administration, stock checking and disposal of medicines. Since our last inspection the service had introduced an electronic medicines system, which enhanced management oversight. The system issued an alert when medicines stock was running low and managers could see any instances where staff had used the electronic device to scan the wrong medicines box. This helped managers identify staff who may need additional training or guidance.
● People and families confirmed safe medicines support was provided. A relative advised, "Yes they deal with it all, they order medication and make sure she gets everything…one time the doctor put him on a medication and it was clear it did not agree with him and they got the doctor back to change the medication." A second relative added, "They always get things double checked…they will phone when medication is changed; no problem with medication."
● Records showed, and staff told us, they had received support, training and competency observations, when the electronic medicines system was introduced. Staff felt the system was more efficient and user-friendly in comparison with paper medicine records. An electronic device identified when medicines were due and staff scanned each medicines box to verify they had selected the correct medicine. Staff felt this helped reduce the risk of errors. A staff member advised, "I love the system, [a] lot easier."
● Some people were prescribed as and when required (PRN) medicines. Detailed PRN protocols were kept with the medicines trolley. Care plans referred to PRN medicines such as pain relief or inhalers, but we found the level of detail within care plans to describe when PRN medicines were required was variable. This meant there was a risk of staff referring to care plans which lacked sufficient guidance. One person was prescribed a PRN inhaler and the care plan advised, "[Person's name] has three prescribed inhalers, two which are administered by staff using a spacer." Staff accounts regarding when the PRN inhaler was required differed. For example, one staff explained they would observe the person for a repeated cough and shortness of breath, a second staff stated they observed the person for wheezing and laboured breathing. The service was responsive to our feedback and agreed to review the record.
● Paper records had been retained to document the application of prescribed creams following personal care. At our last inspection we found topical medicine application records (TMARs) indicated cream was

only applied twice a day, which did not reflect the number of personal care episodes seen in daily records or that personal care needs were regularly attended too. At this inspection we found documentation had significantly improved, although from reviewing five people's records we did identify some isolated instances where staff had documented electronically that cream was applied but had not signed the TMAR. The manager explained additional support would be given to staff to improve compliance.

Preventing and controlling infection

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

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 12.

● The provider was preventing visitors from catching and spreading infections. We observed good signage at building entrances, people were asked questions about symptoms or exposure to COVID-19, temperatures were taken, and facilities were in place for visitors to take a COVID-19 lateral flow test.
● The visiting policy in place enabled family and friends to book visit slots with people using the service. Visits took place in the garden or an indoor visiting room. The visiting room was observed to be clean, chairs were spaced to encourage social distancing and the room had good ventilation. A relative explained, "When the first lockdown came it was a total lockdown; then limited visits, but now we have to make an appointment and visit in an isolated room, we do lateral flow test and sit and wait and if clear, we can go in and given a mask."
● Since our last inspection excess clutter had been removed from communal areas to help facilitate social distancing. Zoning signage was in place to clearly identify the level of risk, and minimum level of personal protective equipment (PPE) required in each area of the building. The home environment was clean, we observed suitable supplies of cleaning products, and cleaning schedules were completed to a good standard. Housekeeping staff and care staff worked together to promote good hygiene, including the sanitisation of high touch points.
● Records showed, and staff told us, the provider was accessing testing for people using the service and staff. The service had sufficient supplies of PPE and staff had received training in relation to infection control. People confirmed staff consistently wore masks and we observed separate and well organised spaces for the donning and doffing of PPE. Senior staff working as shift leaders conducted spot checks to ensure staff used PPE appropriately.
● During our inspection we observed some isolated examples of poor practice which were immediately followed up by the service. These included a staff member wearing a bracelet, reduced ventilation in communal area, a staff member in the laundry room with a mask under their chin and items including a pet carrier in close proximity to a staff area sink, which could have been contaminated by water splashes. We also observed cracks in the kitchen flooring which could have harboured contamination. The interim manager explained they had asked for the kitchen flooring to be repaired and confirmed they would escalate this matter further.
● The provider's infection prevention and control policy had been updated in response to COVID-19. The service had also developed separate risk assessments to document how infection outbreaks can be effectively prevented or managed. We identified certain risk assessments were not easily accessible at the time of our inspection, however staff advised how risks would be managed. Due to the limited number of people using the service, we were told the empty upstairs unit would be used as an isolation space and staff were aware of requirements in relation to the handling of waste and laundry.

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 the last inspection this key question was rated as inadequate. At this inspection this key question has now improved 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.

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

At our last inspection we found people's next of kin were informed of incidents, but the provider were unable to evidence that a written response had been provided as is required under the duty of candour regulation. This is a breach of Regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 20.

● The provider had a duty of candour policy in place, however staff we spoke with had varying levels of knowledge in relation to the duty of candour, including a member of staff who had not heard of the duty of candour. The interim manager explained they had discussed the duty of candour as part of a senior team meeting, however there was no formal training in place for staff in connection with duty of candour. The provider's current action plan identified further planned actions, including an information workshop for staff and the development of standard letter templates to support managers responding to duty of candour incidents. However, the plan confirmed some of these actions had not yet commenced at the time of our inspection.
● Since our last inspection one person had sustained an accidental fall which resulted in hospitalisation and medical treatment for a fracture. The service had failed to recognise the incident met the criteria for a written duty of candour response, as a notifiable safety incident. Whilst the manager and interim manager demonstrated some understanding of duty of candour principles, the service had failed to correctly apply the notifiable safety incident criteria on this occasion.

Effective systems were not in place to ensure all staff understood and met the legal requirements of the duty of candour. This was a continued breach Regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The legal requirements of the duty of candour were not met, however we found the service had generally been open and transparent with people and families. This included updating families following our last inspection when the service entered special measures. Comments from family members included, "During

lockdown it was a bit hit and miss, but now they ring straight away and tell if we can't visit" and "I would ring in often; but they would call if dad had a fall or something is needed…there was an incident where dad rang the police [due to confusion] and they did not communicate that to me and I was a bit upset about that – I believe it was before the new management though."
● Notifications to CQC were no longer delegated to other staff, which meant there was management oversight. This would enable management to review whether a duty of candour response was required, although this had not been effective for the incident we reviewed involving a fracture.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection records viewed indicated a lack of understanding and application of the Mental Capacity Act 2005. This was a breach of Regulation 11 (Consent to care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 11.

● 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. We found the recording of mental capacity assessments and best interests decisions was inconsistent. Records often lacked detail and in some cases did not evidence how decisions taken had been determined in the person's best interests.
● People's care plans included a mental capacity assessment which indicated if a person had capacity to make a decision about continuing to live at the service. Where it was deemed a person did not have capacity, MCAs were documented, however these lacked detail and were not decision specific. For example, people who were assessed as not having capacity did not have mental capacity assessments for medicine administration or support with personal care which they sometimes declined. Best interests documentation lacked detail. For example, a best interests decision for one person simply stated, "It is in [person name's] best interests to remain living at Swan House". There was no rationale as to how this decision was reached.
● People's records contained a medication assessment which documented whether the person or family had signed an agreement form for medicines to be managed by staff. For two people a consent form was signed by family members, however the assessment did not document how the person's own capacity to consent had been explored. Another person was living with dementia and the assessment indicated they had signed the medication consent form. It was unclear how this person's capacity to understand and consent had been considered.
● One person had a door sensor in place due to their risk of wandering into other people's rooms at night. At the time of our inspection the door sensor had been temporarily disabled as the alarm had disturbed other people, and new equipment was on order. However there was a period of time when the door sensor had been in use to monitor whether the person left their room. We found no MCA documented to consider whether the person could consent to their movements being monitored via the sensor.

Records viewed indicated a lack of understanding and application of the Mental Capacity Act 2005. This was a continued breach of Regulation 11 (Consent to care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was responsive to our feedback and explained senior staff had already been offered support and additional training to improve awareness of mental capacity.

● Staff received training in relation to mental capacity and Deprivation of Liberty Safeguards (DoLS). We viewed a recent example of a mental capacity and best interests assessment undertaken in August 2021 and found signs of improvement. A decision was undertaken to purchase a falls sensor mat for a person living with dementia. Documentation showed the person's family had been consulted to agree a sensor was in the person's best interests, due to a history of forgetting their walking aid, placing them at risk of falls.
● People's records documented whether they had a DNACPR in place. DNACPR stands for do not attempt cardiopulmonary resuscitation and a DNACPR form is used where a decision has been reached that if the person's heart or breathing stop, cardiopulmonary resuscitation (CPR) should not be attempted. Some people using the service had appointed a Lasting Power of Attorney (LPOA). We saw evidence LPOA documentation was checked and found this stored at the office.
● We observed staff supporting people living with dementia. Staff communicated with people in a respectful manner, offered choice, such as offering a choice of meals, and sought consent before assisting people. Records also documented staff had sought consent before assisting people in their rooms with personal care needs.

● Most people we spoke with felt the service was well managed. Some residents recalled interactions with the service's new manager. People's comments included, "Very pleasant gentleman, very easy to talk to", "Seems quite nice" and "Very jovial sort of person." People described positive interactions with staff, most people enjoyed the food choices offered, and people described the atmosphere of the home using phrases such as, "A happy atmosphere, very friendly" and "Good. Staff very friendly." We observed people appeared relaxed in the company of staff, and people resting in their rooms were observed to have call bells within reach.
● Relatives told us the service was well managed. One relative told us, "I met the new manager on Sunday, he was very approachable, it seems very good…The previous manager would delegate even when we had an appointment; we never had any engagement with her." A second relative advised, "Yes as far as I can make out…there seems to have been improvements, managers seem to know what they are doing – much better than a year ago." A third relative commented, "What I have noticed is familiar faces that I know and dad knows…that continuity for dad is really good – massive improvement is the management side 100%."
● At our last inspection we found managers were not visible on the units and had delegated the running of the home to senior staff without oversight. At this inspection we found the manager was a visible and supportive presence for staff. Paperwork had been streamlined and certain tasks such as assessing potential new referrals to the home were carried out by the manager. A staff member told us, "It feels as if pressure lifted." A second staff member added, "I think staff morale is lifting…since new manager come, just lifted everyone's morale, he's so approachable. He comes on the unit. If you want to chat, door always open, didn't have that before." A third staff member advised, "Seniors have put a lot of overtime…worked with managers to get things up to speed. When [interim manager name] took over – been absolutely amazing. Every weekend [manager's name] has called to ask if everything ok…we never really had that…so much better."
● Work was continuing to promote a positive staff culture. Workshops were held to raise awareness of personality and communication styles to promote effective team communication. Further team building training was scheduled. Staff workshops had been held to promote quality assurance and auditing systems, to help staff understand how these processes helped monitor and improve care quality. We observed written records such as daily care records and personal care charts were significantly better documented, although we did identify some gaps in records, such as the reasons missing from some food and fluid charts, and gaps in one person's mattress check chart.
● Staff spoke with insight and warmth about people they support. People's care plans contained a profile outlining what was important to the person, including any religious or cultural needs. Survey results indicated for 50% of residents accessing a church service was something they enjoyed and wished to

partake in. At the time of our inspection, regular support to attend church services had stopped due to COVID-19. We were advised the activities coordinator planned further follow up with the church and that people's wishes to access religious pastoral care would be met if someone developed end of life care needs.
● We observed, and management acknowledged, previous staff recruitment had not promoted diversity within the team. For example, at the time of our inspection 40 percent of residents were male but there were no male care assistants employed. Whilst people did not express any objections to being supported by female staff, for certain male residents, having male company was important. One person wished be supported to the pub and preferred a male staff member for social interaction. This was being followed up with the local authority to seek funding for extra-support. The manager described their commitment to encouraging greater staff awareness of equality and diversity.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider failed to make the required notifications to us in a timely manner. This was a continued breach of Regulation 18 (Registration Regulations 2009).

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 18.

● Providers and registered managers are required to notify us of certain incidents which have occurred during, or as a result of, the provision of care and support to people. Since our last inspection, notifications in relation to safeguarding concerns or serious injury had been submitted to CQC in accordance with requirements. During our inspection we identified one safeguarding concern which had not been shared with CQC, however we were satisfied other concerns had been appropriately reported. The interim manager submitted the notification retrospectively within 24 hours of the omission being identified.

At our last inspection people were not cared for by a service that was effectively managed and monitored. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 17.

● There was no registered manager in place. Following our last inspection the registered manager left the service. A manager employed by the provider at another service provided interim manager cover for Swan House and the connected extra-care setting Swan Court. The interim manager had supported staff with the implementation of improvements at the service. A manager had been recruited who commenced work in August 2021.
● The manager and the staff team were clear of their roles and responsibilities. The manager understood their responsibilities in relation to regulatory requirements and demonstrated commitment to their own professional development and to continuing improvements at the service. They advised, "I want to see positivity…I always want to improve care and service."
● Systems were in place to audit the service. We reviewed service audits in areas such as care plans, health and safety, housekeeping, infection control, medicines management and catering. The majority of audits had been completed in line with the provider's schedule. The quarterly catering audit was overdue and we were advised this had been on hold pending a change of catering supplier, however at the time of our inspection there was no confirmed start date, meaning it was unclear when the next audit would take place.

The manager had completed their own quality monitoring of the kitchen environment and meals, which included photo evidence to check food quality and appearance.
● The provider carried out a series of audits and held regular quality panel meetings to review the service's progress against their improvement plan. This showed the provider was monitoring some of the issues we identified, such as the completion of topical medicines administration records. Minutes also demonstrated the provider had considered what resources were required to support improvements, such as recruiting an administrator.
● Since our last inspection the service replaced paper care plans with electronic care plans. These could be more easily updated when people's needs changed. Care plan audits provided staff with practical guidance and we observed care plans had been updated in response to feedback. Whilst the quality of care plans had improved significantly since our last inspection, we identified some areas where staff required more detailed information. For example, one person using the service was diagnosed with a condition affecting their circulation. The care plan contained no description of the medical condition. We spoke with four staff; two staff were not familiar with the condition, and one thought it related to the person's stomach. The information about people's medical conditions remained variable and the service agreed to review our feedback.

We recommend the provider ensures staff have access to sufficient information about people's health to enable staff to understand the impact and potential risks for each person associated with their medical conditions. This means providing staff with information to enable them to provide person-centred care and identify risks, including signs of deterioration.

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

At our last inspection the service had failed to effectively seek and act on feedback from relevant persons, including staff and people using the service. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 17.

● Engagement with people was largely informal although some surveys had been used. No resident meetings had been held since our last inspection. The activities coordinator had used a questionnaire to gather the views of people in relation to their preferred activities and the new manager had met with residents informally. Easy to read posters were displayed with information about how to give feedback or raise a complaint. Some people we spoke with could not recall when changes had been made in response to feedback. One person living with dementia told us they had answered some questions in a questionnaire and said action had been taken around six weeks afterwards; they gestured to the easy-read poster to explain they had instructions if they needed to give feedback.
● Meetings had been held with relatives in January 2021 and March 2021 to provide updates about planned improvements following our last inspection. We found no subsequent formal meetings had taken place, although a survey had been undertaken to gather views of people and their relatives. The service had provided email updates to families, such as in relation to visiting arrangements, and the new manager of the service was working to introduce themselves to relatives. One relative commented, "I have been impressed with the new manager, I did not know the previous woman manager and I did not meet [interim manager's name] because he has two homes to run, but [manager's name] has introduced himself to us and has been instrumental in getting dad settled".

● Staff meetings were held infrequently. Staff we spoke with felt engaged in the improvement process and told us they felt able to give feedback and suggestions. One staff member commented, "The manager's office door is always open, can always pop and chat to them." The provider carried out an annual staff survey and we viewed the action plan in place, which included ensuring staff received regular supervision. We were satisfied the provider was taking action to ensure staff received supervision although some yearly appraisals were overdue.
● The service had engaged with other stakeholders to help identify improvements for the service. This included supporting a local authority commissioning review, a visit by the home's regular pharmacist, and a review by the local clinical commissioning group to assess medicines management. We observed changes made, such as clearer labelling of trays containing medicines.

Working in partnership with others
● Professional feedback indicated the service worked effectively in partnership with other organisations. The service had links with key organisations including GP, district nurses, physiotherapy, mental health team and speech and language therapy. We received a number of positive comments from professionals who had worked with the service. One professional commented, "Was a clean and homely environment… [staff have] always been very professional, very friendly, helpful." A second professional commented, "[They have] always been very professional with me, I feel they engage us at the right time, pretty attentive, if they have concerns regarding mental health of patients, they will get in touch with us."
● The service had effective systems in place to share information with other professionals. This included giving authorised professionals access to the service's electronic care system to view care plans and daily records. This had benefited both the local authority and CQC in assessing the service's compliance. A GP also explained this supported partnership working, as they were able to review daily records including weight checks, to help them assess concerns. The GP commented, "If I get a message…for example, if they rang and said [person had] lost weight, I usually go back and look at weights…check normal range, might be matter of reassuring them…I always found them to go over and above."
● Prior to the COVID-19 pandemic we were told the service was actively involved in the local community and local school children came to the service. At our last inspection we found this had stopped in line with the restrictions imposed on visitors to the home. At this inspection we found the service continued to have some limited links with local organisations following COVID-19 restrictions. We were advised the service had started to re-establish links with other organisations and were told this work would continue.

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 11 HSCA RA Regulations 2014 Need for consent Records showed the service did not work to the principles of the Mental Capacity Act 2005.

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