Absolute Healthcare Swan House Limited

Swan House

Inspection report

Pooles Lane
Short Heath
Willenhall
West Midlands
WV12 5HJ

Tel: 01922407040

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14 December 2023

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Swan House is a care home providing nursing and personal care for up to 45 people. The service provides support to people who are both residential and nursing care. Some of the people in the home were live with dementia. People have access to their own bedroom along with communal spaces including lounges. The home is split between 2 floors, the lower provides residential care and the upper floor provides nursing care. At the time of our inspection 28 people were living in the home.

People's experience of using this service and what we found
This was a targeted inspection that considered the assessment, monitoring and management of risk and the clinical leadership and oversight of the service. Our inspection focused only on people who were receiving nursing care at the service. Based on our inspection of these areas we found:

People remained at risk of preventable harm from falling and choking. Safe systems were not in place to enable staff to effectively identify when peoples' health was deteriorating, which meant people were at risk of not receiving timely medical support to keep them well.

Effective systems were not in place to consistently identify safety and quality concerns. This meant prompt and effective action was not taken to improve safety and quality.

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 the service was inadequate and there were breaches of regulation (published 19 January 2024). The service was placed into special measures and we followed our agreed regulatory response.
At this inspection we found the provider remained in breach of regulations.

Why we inspected
We undertook this targeted inspection to check on ongoing concerns from people who visited the service relating to the safety and quality of the care provided. We had also received concerns about the management of peoples' health when their health deteriorated. A decision was made for us to inspect and examine those risks.

The overall rating for the service has not changed following this targeted inspection and remains inadequate.

We use targeted inspections to follow up on Warning Notices or to check concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

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 and Recommendations
We have identified breaches in relation to safe care and treatment and the clinical oversight at the service at this inspection.
You can see what action we have asked the provider to take at the end of this full report.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

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 Health and Social Care Act 2008.

This was a targeted inspection to check on a concerns we had about the assessment and management of risk, including the management of peoples' health when their health deteriorated and concerns about clinical oversight and leadership. Our inspection focused only on people who were receiving nursing care at the service.

Inspection team
The inspection was carried out by an inspector and operations manager.

Service and service type
Swan House 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. Swan House 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. However, a home manager was in post who was in the process of registering with us.

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 all this information to plan our inspection.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with 4 people and 5 relatives. We spoke with the provider, the regional manager, the home manager, the deputy manager, 2 nurses and 2 care staff. The provider had employed consultants to work at the service to support with making improvements. We therefore also spoke with staff from the consultancy team.

We looked at the care records for 4 people who were receiving nursing care. We checked the care people received matched the information in their records.

Inspected but not rated

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 this key question was rated inadequate. We have not changed the rating as we have not looked at all of the safe key question at this inspection.

The purpose of this inspection was to check on concerns we had about the assessment and management of risk, including the risks associated with deteriorating health and the concerns about clinical oversight and leadership.

We will assess the whole key question at the next focused or comprehensive inspection of the service.

At our last inspection the provider had failed to assess, monitor and mitigate risks to people's health, safety and welfare. This was a breach of regulation 12 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 12.

Assessing risk, safety monitoring and management and learning lessons when things go wrong
• Risks to people's safety continued to not be consistently and effectively managed to protect people from the risk of significant harm. This included the risk of falling and choking.
• We continued to find that safety information in people's care plans was not always up to date or sufficient to guide staff to keep people safe. For example, advice from a visiting health care professional had not been incorporated in a person's care plan or communicated to staff. This meant staff were not always following professional advice to keep people safe.
• We continued to find that where guidance was contained in people's care plans to guide staff in how to keep people safe, this was not always followed. For example, equipment prescribed to minimise the risk of harm from falling continued to not be consistently used, placing people at risk of harm.
• Best practice guidance was not followed to ensure timely action was taken in response to people whose health was deteriorating. For example, clinical observations (such as blood pressure and temperature) were not always completed in line with best practice when people's health started to deteriorate. This resulted in delays in identifying when medical advice and support was required.
• The provider continued to not take effective action in response to incidents at the service. For example, 1 person had fallen on 3 occasions between the 1 and 5 of December 2023. No effective action had been taken to reduce the risk of this person from falling following each fall, placing them at risk of harm.
• The provider failed to ensure effective action and learning was completed following local authority safeguarding investigations. For example, the local authority had identified a person's prescribed medicines were being stored in their bedroom which posed a risk of other people accessing or tampering with the medicines which could result in harm. During our inspection, we identified this medicine was still accessible to people in the person's bedroom.

• During the inspection CQC staff intervened on multiple occasions to ensure action was taken to keep people safe. For example, on 3 occasions we informed staff that a person's falls equipment was not being used as prescribed.

The provider continued to not effectively assess, monitor and mitigate risks to people's health, safety and welfare. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspected but not rated

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 this key question was rated inadequate. We have not changed the rating as we have not looked at all of the safe key question at this inspection.

The purpose of this inspection was to check on concerns we had about the assessment and management of risk, including the risks associated with deteriorating health and the concerns about clinical oversight and leadership.

We will assess the whole key question at the next focused or comprehensive inspection of the service.

At our last inspection there was a lack of oversight and effective systems of governance in the home. This was a breach of regulation 17 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 17.

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

- The provider continued to fail to ensure effective leadership was present at the service.
- There was no effective clinical oversight at the service and managers and the provider had failed to identify and take prompt action to the unsafe care being provided to people. For example, neither the managers or provider were effectively observing care or effectively reviewing the quality of records. Therefore, they failed to identify and take action to the ongoing high level safety concerns we identified during this inspection and previous inspections.
- The provider had sought support from external consultants to support in making improvements to safety and quality. However, despite this action, at the time of this inspection, this support had not addressed the ongoing high level safety concerns we identified and raised at this inspection and previous inspections.
- As a result of ineffective leadership and clinical oversight at the service, the provider remained in breach of multiple regulations.

There continued to be a lack of effective oversight and effective systems continued to not be in place to consistently identify safety and quality concerns. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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
Treatment of disease, disorder or injury	The provider continued to not effectively assess, monitor and mitigate risks to people's health, safety and welfare.

The enforcement action we took:

We urgently imposed a condition on the provider's registration that prevented them from providing nursing care at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	There continued to be a lack of effective oversight and effective systems continued to not be in place to consistently identify safety and quality concerns.

The enforcement action we took:

We urgently imposed a condition on the provider's registration that prevented them from providing nursing care at the service.