R G Care Ltd

Swan Care Residential Home

Inspection report

29 North Street
Tillingham
Essex
CM0 7TR

Tel: 01621779171

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Swan Care Residential Home provides accommodation and personal care for up to 21 older people some of whom may be living with dementia. At the time of the inspection 13 people were living in the service.

People's experience of using this service and what we found
The provider's infection prevention and control processes did not protect people from the risk of harm. The provider had not followed government guidelines. During the inspection we found senior members of staff who had tested positive for COVID-19 working in the service.

Personal Protective Equipment (PPE) was not always stored or used effectively and some communal areas of the service were unclean.

The provider had not notified health professionals promptly during the outbreak of COVID-19 in the service. This meant people were at risk from not receiving appropriate care and support to meet their health needs.

The provider did not have robust processes in place to ensure they had oversight of the safety and quality of the service. The concerns found at inspection had not been identified by the checks and audits completed by the provider.

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

Rating at last inspection
The last comprehensive inspection rating for this service was good (published 12 February 2018).

Why we inspected
We received concerns in relation to the management of infection prevention and control in the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.
We have found evidence that the provider needs to make improvement. Please see the Safe 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.

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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Swan Care residential Home 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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to infection prevention and control, the oversight of the service and the actions taken by the registered manager. Please see the action we have told the provider to take at the end of this report.

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Swan Care Residential Home

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 two inspectors.

Service and service type
Swan Care Residential Home 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 had a manager registered with the Care Quality Commission. This means that 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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We used observations to gather evidence of people's experience of care. We spoke with the provider, registered manager, care staff and the chef. We viewed a limited number of key records to minimise our time at the service.

After the inspection
We spoke with four relatives about their experience of the care provided. We continued to seek clarification from the provider to validate evidence found on inspection and reviewed a range of records including two people's care plans, training data and a variety of records relating to the management of the service.

Inadequate

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 Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

- People were not protected from the risk of infection. At the time of the inspection the service had an outbreak of COVID-19. Senior members of staff who had tested positive for COVID-19 continued to work in the service and were not self-isolating in line with government guidance for positive COVID-19 test results.
- Personal Protective Equipment (PPE) was not worn appropriately. The registered manager was observed wearing their mask below their chin, despite being positive for COVID-19. This meant people and staff were at risk from the spread of infection.
- PPE was not stored in a suitable area. Aprons were left hanging from railings in the hallway and in bathroom sinks. Some were visibly stained. This meant there was a risk of contamination to the PPE prior to its use.
- Some communal areas were unclean. Bathrooms contained stained and unclean equipment and toilets were visibly dirty. The laundry area did not have a clear system for the management of contaminated clothing, we observed clean and dirty laundry mixed together. This meant people were at risk from cross infection.
- Cleaning rotas and infection control audits were not effective and had failed to identify the issues we found on inspection.

The above issues were a breach of Regulation 12 (Safe Care and Treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not protected from the risk of harm caused by poor infection prevention and control measures.

Assessing risk, safety monitoring and management

- The provider had not managed the risk of COVID-19 safely. The GP had not been notified promptly when people tested positive for COVID-19. This meant people were at risk of not receiving appropriate care and treatment.
- The provider had failed to manage environmental risks within the service. Health and safety audits had not highlighted any concerns with the cleanliness or condition of the building. However, during the inspection we observed unclean and stained equipment.
- The provider had implemented an electronic system for people's care plans and risk assessments and there was evidence risks to people had been assessed and reviewed. However, the provider had failed to assess and manage the risks to people's health and safety caused by the COVID-19 outbreak.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- The provider kept a record of safeguarding concerns raised and actions taken. However, they had not always shared lessons learnt from incidents with staff. For example, following our inspection where serious

concerns had been raised regarding the management of COVID-19, there was no record of this being discussed in the subsequent staff meeting. This meant we could not be assured staff were involved in learning from when things went wrong.

● The provider could not evidence that all staff had up to date safeguarding training. Following the inspection, the provider confirmed this had been booked.

Using medicines safely

● Staff had received training in the administration of medicines. However, the provider could not evidence this training had been updated regularly. Following the inspection, the registered manager confirmed medicines training had been booked.

● The provider had undertaken regular medicines audits and highlighted where administration errors had been made. However, it was not always clear from the audit what action had been taken as a result of administration errors.

Staffing and recruitment

● The provider had not made robust arrangements for the absence of domestic staff to ensure the environment remained clean and hygienic.

● The provider had completed relevant checks during the recruitment process to ensure staff were safely employed.

Inadequate

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 Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The registered manager failed to follow the procedures in place to mitigate the risk of the COVID-19 infection spreading. Prior to the inspection we were informed the registered manager had tested positive for COVID-19 but remained working in the service. We sought an immediate response from the provider who told us the registered manager had been removed from the service to self-isolate. However, on arriving at the service, we found the registered manager was still present. The registered manager confirmed they were COVID-19 positive and removed their face mask whilst speaking to inspectors. They had to be informed of the need to put it on properly. This was a serious breach of the safety procedures in place to mitigate the risk of infection.

The above concerns demonstrated a breach of Regulation 7 (Requirements relating to registered managers) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager did not demonstrate appropriate knowledge of legislation, relevant best practice and guidance.

- Systems in place for managing health and safety and infection prevention and control were not used effectively and failed to identify the concerns we found on inspection.
- The provider did not implement government guidelines for minimising the risk of COVID-19 infection. This placed people at significant risk of illness.

The above concerns demonstrated a breach of Regulation 17 (Good Governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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 was not open and honest with the relevant authorities regarding management oversight during the COVID-19 outbreak in the service. The provider informed the local authority and the Commission that the registered manager would not be working in the service due to testing positive for COVID-19. This was contrary to what we found on inspection.
- We received mixed feedback from staff about the support they received from the provider. Some staff told us they felt well supported. One member of staff said, "I feel very supported, they're very good." However, we also received information from staff who were concerned about working during the COVID-19 outbreak and

felt unable to address these concerns with managers in the service.

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

● Regular staff meetings took place to enable staff to give feedback. However, minutes from the meetings demonstrated that staff had not always been involved in decision making and learning.

● The provider sought feedback from people, relatives and staff through annual satisfaction surveys. Relatives told us they felt involved in people's care. One relative said, "They keep me informed and I speak to the manager regularly."

Continuous learning and improving care; Working in partnership with others

● The provider failed to notify health professionals in a timely manner when people had tested positive for COVID-19. This lack of partnership working placed people at risk from not receiving the appropriate care.

● Following the inspection, we asked the provider to complete an action plan to demonstrate how improvements would be made in the service. The provider implemented an action plan, identifying immediate improvements and updated the relevant authorities of the progress made.

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 People were not protected from the risk of harm caused by poor infection prevention and control measures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place for managing the safety and quality of the service were not used effectively

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 7 HSCA RA Regulations 2014 Requirements relating to registered managers The registered manager did not demonstrate appropriate knowledge of legislation, relevant best practice and guidance.