Absolute Healthcare Swan House Limited

Swan House

Inspection report

Pooles Lane
Short Heath
Willenhall
West Midlands
WV12 5HJ

Tel: 01922407040

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Swan House is a care home providing 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 are living with dementia. People have access to their own bedroom along with communal spaces including lounges. The home is split between 2 floors, lower is residential and the upper is nursing care. At the time of our inspection 40 people were living in the home.

People's experience of using this service and what we found
The service was not safe. Risks to people were not monitored or reviewed after incidents or changes occurred and people were not protected from harm. Care plans and risk assessments lacked detailed, and actions implemented to keep people safe were not followed. People did not always receive pain relief when needed and medicines were not always safely managed, as stock checks were inaccurate, and bottles opened were not dated.

There were not enough suitably recruited staff to support people. The lack of leadership in the home meant the staff were not safely deployed, and they did not have the training, skills or knowledge to support people.

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

Safeguarding procedures were in place and followed to report concerns there was a lack of accountability in the home with regards to this.

The systems in place to monitor the home, the care people received were not effective as they had failed to identify concerns. There was lack of learning lessons as action had not been taken since the last inspection to make the necessary improvements to comply with a warning notice . The home was not well managed. There was a lack of understanding from staff on their roles and there was no leadership in the home, placing people at risk.

The home was clean on the day of our inspection. Signage had been used to support people living with dementia.

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 rating for the service was requires improvements (Published 13 November 2023)
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 the provider remained in breach of regulations.
You can see what action we have asked the provider to take at the end of this full report.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.
You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to how people's risks were managed, staffing and their training, how people consented to their care, the lack of governance and leadership in the home. The diets that people received.

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 request an action plan from 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 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 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

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.

Inspection team
The inspection was carried out by 3 inspector and 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.

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 is a manager in post who is in the process of registering with us.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since our last inspection, including notifications the provider had sent to us and information we have received from members of the public and the local

authority. We used the information the provider sent us in the provider information return (PIR). 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 of this information to plan our inspection.

During the inspection
We spoke with 8 people and 7 relatives or friends. We spoke with the manager, the deputy manager, the nurse, the housekeeper and 7 care staff. We looked at the care records for 18 people. We checked the care people received matched the information in their records. We looked at records relating to the management of the service, including audits carried out within the service and staff recruitment checks.

After the inspection we continued to received information from concern from the local authority and member of the public including relatives.

Inadequate

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 requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

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. We also issued a warning notice.

Not enough improvement had been made at this inspection and the provider was in breach of regulation 12. The warning notice had not been complied with.

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

- Individual risks to people continued to not be assessed monitored and reviewed. When incidents or changes had occurred, care plans were not in place to reflect these changes or at all.
- When people did have care plans in place, we saw these were not always followed. For example, we saw 1 person mobilising independently without equipment when their care plan stated they needed supervision and a Zimmer frame. This meant people were placed at risk of harm as guidance in place to keep people safe was not followed.
- When people had displayed periods of emotional distress, we saw these incidents were documented. However, there was no detailed guidance, care plans or risk assessments to show how to support people during these times. These incidents continued to occur, and this had resulted in assaults on people living in the home. This placed people at risk of significant harm.
- Several incidents of altercations or assaults had been recorded. The manager told us they had implemented a staff member on 'corridor watch' to reduce the risk of these reoccurring. During our inspection we saw numerous times when this was not implemented, and a staff member was not present. Unwitnessed incidents had continued to occur since this had been implemented. This placed people at risk of continued harm.
- People were placed at an increased risk of choking. One person had recently choked on a food item and first aid had been carried out. There was no reference in the persons care plan in relation to this. The care plan in place stated their food should be cut up. We saw this person eating food that was not cut up including pieces of beef, carrots and a whole Yorkshire pudding, we discussed this was a staff member, who was sat next to them. They were not aware of how this person's diet should have been provided. We had to ask the deputy manager to intervene. This placed this person at an increased and further risk of choking.
- Equipment that was used to keep people safe and reduce the risk of falling was not effective, we found these sensors were not switched on, were not in working order and did not activate when we walked in front of these. This placed people at risk of further falls and significant harm.
- When incidents had occurred, action was not taken to ensure people were safe. During our inspection 1

person had an unwitnessed fall, sustaining a head injury. We saw they were unsupervised in their bedroom whilst they waited for an ambulance. We discussed this with the manager and deputy who confirmed the protocol following a fall, was that the person should not have been left unattended during this time. This meant this person was not observed and safe following a fall that had resulted in a head injury.

● People did not have access to call bells when in their room so were unable to access support when needed. We saw several call bells were not in reach and some were unplugged. This meant people could not press these if needed. Others had been assessed as unable to use the call bells, which our observations did not support.

● The provider had failed to ensure lessons were learnt when things went wrong. There was no evidence action was taken after incidents occurred. Concerns identified at our last inspection had not been actioned to ensure people were safe and has resulted in a deterioration in the rating of the service and failure to comply with enforcement action we took.

Medicines management

● People did not receive pain relief when needed. We heard 1 person request pain relief as they were experiencing pain. This person was not provided with this, which meant the person was left in pain.

Risks to people continued too not be effectively managed. People were not provided with pain relief when needed. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After our inspection we told the provider to take action to keep people safe. We requested detail including an action plan showing how they were going to complete this, we shared our findings with the local authority and raised safeguarding alerts. We will review the action the provider has told us they have taken as part of our next inspection.

At our last inspection the provider had failed to implement robust recruitment processes.

This was a breach of regulation 19 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.

Staff and recruitment

● The provider had taken action to ensure checks were in place for staff working at the home including references and police checks. However, for 1 person we found they had gaps in their employment history and another person's identification used was out of date. This meant further improvements were needed to ensure checks were robust.

● There were not enough staff deployed to keep people safe. The system for working out how many staff were needed was not effective. We found people with the same scores had differing levels of need and we could not be assured this was an accurate assessment of people's needs.

● People and relatives raised concerns. One person said, "I am just waiting for someone to come and wash and dress me. This time is normal, but it's quite late for me. I would prefer it to be earlier. Sometimes they are short of staff, I don't know about today though". It was 9:45am when they raised concerns with us. Another person told us, "Everything is wrong here. Look it's 10.15am and I'm still in my nightwear. Others are up and dressed. I'm not. I'm here in my room." Relatives also told us they came in at lunchtime to support people as they felt they would not get the supported needed if they did not.

● Staff were not available to offer support needed to keep people safe. One person who needed supervision to mobilise was mobilising independently. The systems [corridor watch] the manager told us they had implemented to observe people and keep them safe were not followed by staff. This placed people at risk of harm.

There were not enough staff available or deployed for people to keep them safe. This placed people at risk of harm. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Systems and processes to safeguard people from the risk of abuse
● There were procedures in place to identify and report safeguarding concerns.
● There was a lack of understand from the manager, deputy manager and staff around their responsibilities. For example, when incidents had occurred these were raised as safeguarding concerns when needed, however no other action was taken, including investigations or measures to keep people safe whilst these were reviewed and considered. By delegating this to the safeguarding team it demonstrated a lack of understanding around their responsibilities.
● Not all staff had received safeguarding training. The training matrix we reviewed confirmed this. We could not be assured safeguarding was fully understood. For example, we saw 1 person hit another person on the back of their legs with their frame, staff were present when this happened however this was not documented and accepted as something that occurred frequently. This placed people at risk of potential abuse or harm.

People were not always protected from potential abuse. This placed people at risk of harm. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Medicines management
● Medicines were not always managed in a safe way. We found bottles containing liquid had not been dated when they were opened. This meant we could not be assured it was in date and safe to use.
● We found not all stock checks had been recorded accurately. This meant we could not be assured people had received all medicines as required.
● When people had 'as required medicines' there were protocols in place stating when this should be administered.
● Staff told us they had received training in medicines management and had their competency checked to ensure they were safe to administer medicines.

Preventing and controlling infection
● Although the home appeared clean on the day of our inspection, we could not be assured infection control procedures were followed as an external audit has been completed and significant concerns identified.
● We saw staff were wearing Personal Protective Equipment (PPE) when needed and people and relatives we spoke with raised no concerns.

Inadequate

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 requires improvement. The rating for this key question has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

At our last inspection the provider had failed to follow the principles of The Mental Capacity Act 2005 (MCA).

This was a breach of regulation 11 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 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. 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 checked whether the service was working within the principles of the MCA.

- Capacity had not always been assessed when needed. For example, 2 people were receiving their medicines covertly. Covert medicines are medicines that are administered in a disguised format and the person does not know they are taking them. There were no MCA or best interest's decisions in place for these, despite the people being unable to consent to this. This meant decisions were being made on people's behalf without legal authority.
- After our last inspection we raised concerns that people had not consented to CCTV that was in place. We found the same concerns at this inspection.
- When capacity assessments had been completed, it was unclear why the area was being assessed or how the decision was made. For example, 1 person had a capacity assessment to consent to an MCA being carried out. There was no rationale as to why this would be needed or evidence to show how the decision

had been made.
● We did not see any best interest decisions in place for people, despite it being documented decisions had been made in people's best interests.
● There was a lack of understanding from the manager and staff around what MCA was. Staff had not always received up to date training in this area.

The principles of MCA continued not to be followed. This is a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People were at risk of weight loss and action was not taken. One person had lost significant weight and required weekly weight checks, however these were not completed. We observed this person was not supported to eat and drink effectively during the inspection and there was no guidance in place for staff which left the person at risk of not eating and further weight loss.
● Care plans lacked detail of how to support people with specialist diets. A care plan was in place identifying a specialist diet for one person which offered limited guidance for staff. This person's relatives told us they were concerned about the diet they received. They said, "My relation is on a specialist diet, but staff give them food with [food they cannot have]. They offered them biscuits that they shouldn't have. We have insisted on a sign being up on the wall but they still do it." Staff were unable to describe this person's needs which meant the person was at an increased risk of significant harm.
● We saw another person was in bed with their food on a table next to them, out of reach. After 35 minutes this remained in the same position uncovered. We raised our concerns with the nurse. They told us the person was unwell they went into the room and removed the meal. They were not offered an alternate meal. This placed this person at risk of not receiving a nutritional balanced diet.
● When people had diabetes there was no clear guidance in place for staff to follow including what foods they could or could not have. For 1 person it was recorded they liked foods that were not representative of a diabetic diet. We discussed this with the manager who told us family brough in these foods for this person. There was no risk assessment in place for this. This meant you had failed to ensure this person received a diabetic diet placing their health at risk of significant harm.

People were not supported to have a healthy diet. This is a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Staff did not always have the skills or knowledge to support people. For example, we reviewed the training matrix this showed that some staff had not received training in areas such infection control, safeguarding, dysphagia and care planning and risk assessments. We raised this as a concern at our last inspection.
● Staff had not received training to support people who had dementia and displayed periods of emotional distress. During our inspection we observed staff did not demonstrate an understanding of this and people were supported in an inconsistent way. Our observations confirmed that when people were distressed, or incidents were taking place staff offered an inconsistent approach. In some instances, this caused further agitation for people. This placed people at risk of harm and continued distress.

Staff did not have update training or an understanding how to support people. This placed people at risk of harm. This was a breach of regulation 18 (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support

● One person had been seen by a dietitian due to weight loss. It was recorded following the visit they had been prescribed a supplement. The deputy manager confirmed they were not available in the home. This meant there was a delay in following advice from health professionals.

● Another person had damaged skin. There was a care plan in place however this lacked detail. It was unclear how the skin should be cleaned and dressed. It was documented the dressing should be changed every 2 days however records we reviewed did not demonstrate this was being completed.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's care plans did not always reflect their current needs. Some people did not have individual care plans, risk assessment or guidance in place at all.

● Some people's needs were assessed prior to the start of their care. However, these were not always updated to reflect changes in their needs or professional advice given.

● People's involvement in the planning and review of their care was not reflected within their care documents.

Adapting service, design, decoration to meet people's needs

● Since the last inspection some signs had been put in place to support people living with dementia.

● Adapted equipment was available to support people, including hoists and bathrooms.

● There was garden available that was accessibly for people living in the home.

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 our last inspection we rated this key question requires improvement. The rating for this key question has changed 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.

At our last inspection the provider had failed to operate good governance. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also issued a warning notice.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Continuous learning and improving care. risks and regulatory requirements.
●Audits and checks had not been carried out consistently and were not effective in identifying the concerns we found at this inspection. This placed people at risk of harm.
● Audits and checks undertaken failed to identify people's care plans and care records were not accurately completed and were not fully reflective of their current needs. Audits did not identify that care plans failed to provide staff with the information and guidance they needed to keep people safe.
● The quality and safety monitoring systems such as checks and audits to identify and respond to areas of improvements were not effective as they had not identified concerns as identified at this inspection.
● Systems and processes failed to identify training and support needs of staff to ensure they were effective in their roles. As the evidence in effective, this placed people at risk of receiving unsafe care.
● The provider had failed to ensure checks were completed on equipment that was used to keep people safe, including sensors and weighing scales placing people at an increased risk of harm.
● Systems and processes had failed to identify that capacity assessments and best interest decisions were not in place for people when needed.
● Systems and processes had failed to identify staff had not always been safely recruited.
● The lack of effective governance leadership and process resulted in a failure to identify and mitigate immediate risk of harm for people living in the home.

There was a lack of oversight and effective systems of governance in the home. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After our inspection we asked the provider to take action to keep people safe. We requested detail including an action plan showing how they were going to complete this, we shared our findings with the local authority and raised safeguarding alerts. We will review the action the provider has told us they have taken as part of our next inspection.

Managers and staff being clear about their roles and understanding quality performance.

● The home was disorganised and there was a lack of leadership. Staff were unclear on their roles. We found it hard to find information about people as the manager and deputy manager were not aware of action taken. For example, we were told a person had been referred for support with their eating and drinking. During our inspection no one could find evidence this had been completed. However, after the inspection this was provided to us.

● We received contradictory information during our inspection. For example, following a fall the nurse told us it was unwitnessed, and the sensor had not been activated, whereas the deputy told us they had heard the sensor and had been alerted to this. This placed people at risk of harm.

● The lack of oversight and leadership placed people at risk. Staff did not know key information about people, including when their diets had changed. At mealtimes the home could be described as chaos, there was no direction for staff, people were not receiving the support they needed, staff did not know where they should be or who they were supporting. This meant some people had to wait for their meals, others did not receive meals and people who did not need support were provided with it.

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

● There was no evidence to show how people and those important to them were involved with their care.

● Although we saw some feedback was sought from people, and there was no evidence to show how this information was used to drive improvements.

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

● Poor communication and oversight were a theme throughout our inspection which did not promote good outcomes for people.

● We could not be assured that people were consistently supported in a person-centred way as staff were not always given clear, written guidance in how to support people and we could not be assured care records were up to date

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

● Whilst the legal responsibilities in relation to the duty of candour was understood, the service had failed to ensure they were aware of all accidents, incidents and near misses at the service so they could ensure they were consistently meeting this. There was a failure to act upon concerns that had occurred in the home.

Working in partnership with others

● The systems in place to ensure referrals made to health professionals were not always effective. For example, when people had falls, relevant referrals were not always made. This meant people did not always receive a professional assessment when needed to mitigate risk to them and ensure they received the appropriate care and treatment.

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 Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from potential abuse.

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	Risks to people were not managed placing people at risk of harm.

The enforcement action we took:

Imposed urgent conditions on the providers registration