Swanton Care & Community Limited

Swanton House Care Centre

Inspection report

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Date of inspection visit:
07 August 2017
09 August 2017

Date of publication:
15 January 2018

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 7 and 9 August 2017 and was unannounced.

Swanton House Care Centre provides residential and nursing care for up to 49 people. It is divided into three units. Holly Court and Bluebell are single story and purpose built. Birch is a converted period building. Some people who used the service needed support with their mental health needs. For other people their needs were age related or they were living with dementia.

Both Birch and Holly Court provided nursing care whilst Bluebell provided residential care only. Those people requiring care for their age related conditions or support whilst living with dementia, lived in Birch. At the time of our inspection there were 46 people living in the home.

At the time of our inspection, there was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However, in order to manage the service, the provider had employed a consultancy agency six weeks prior to this inspection. This consisted of a full time manager and part time clinical lead.

We last inspected this service in April 2017 where we found widespread concerns and failure to meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the April 2017 inspection, we found six breaches to the regulations. These breaches related to safe care and treatment, safeguarding people from abuse and improper treatment, the need for consent, person centred care, staffing and good governance. The provider sent us a plan to tell us about the actions they were going to take to rectify the breach of the regulations. They told us these would be completed by July 2017.

At this inspection, carried out in August 2017, we found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service continued to be in breach of the above six regulations. In addition, the service had failed to treat people with dignity and respect.

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

The provider had been aware of failures within the service for a number of months. The action plan, quality monitoring system and management resources they had in place to address these failures had not been sufficient. We found continued and widespread issues across the service and we had serious concerns about the health, safety and welfare of people who used it.

The risks around people's mental health and associated behaviours had not been mitigated and managed. This put them, and others, at risk of harm or abuse. Clear strategies for supporting people living with

behaviour that may challenge them and others were not consistently in place. Where they were, they were not consistently being followed by staff. In addition, the procedures in place to safeguard people were not fully effective. Staff were stretched to support people in a safe manner.

People's basic needs were met but they did not receive person centred care that was tailored to their individual needs. Care and support was delivered in a task orientated manner. People had not been included in the planning of their care and we saw that consent was not consistently sought prior to support being provided. The social and leisure needs of all those that used the service were not being met with little in place to stimulate or interest them.

Care and support was not consistently provided in a way that maintained people's dignity or in a manner that demonstrated respect. Staff interventions were not consistently empathetic, warm or discreet. Whilst we saw that some staff displayed kindness and compassion, others supported people without any meaningful or effective communication.

There were not enough suitably experienced, skilled or competent staff deployed to meet the needs of the people who used the service. Staff were not consistently trained to the standard the provider deemed necessary and their competency to perform their role had not been fully assessed. Clinical staff's ability to practice had also not been assessed and they lacked the provider's core training. Consequently, the provider could not be assured that people were receiving safe or effective support.

The CQC is required to monitor the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS) and report on what we find. People's human rights had not been respected and the service had not complied with the Act. Conditions attached to authorised DoLS had not been met which had significantly infringed on people's quality of life.

Medicine administration records contained gaps and not all risks associated with this task had been fully mitigated. A number of recent medicine administration errors were currently being investigated and some mitigating factors had been taken however, at the time of our inspection, a medicines audit had not been completed for over two weeks.

Records contained gaps in regards to managing people's nutritional needs and not everyone consistently received the specialist diet they required. People had access to healthcare professionals as required. However records did not consistently demonstrate how, when or if issues were followed up in relation to healthcare needs.

Processes were in place to ensure that only those that were suitable to work in the service were employed. Procedures were also in place that mitigated the risks associated with the premises which included regular equipment maintenance and checks. The service had a complaints policy in place to address any concerns people may have although none had been recorded at the time of this inspection.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any

key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

The procedures the service had in place to help protect people from the risk of abuse or harm were not effective. The risks to people had not been fully identified, assessed or managed which had put people at risk of harm.

There were not consistently enough staff to meet people's needs in a person centred manner and mitigate the risk of harm.

There had been a number of medicine administration errors at the service which were being investigated. However, the control measures the service had put in place to mitigate future risk of misadministration, had not been consistently applied.

Is the service effective?

Inadequate

The service was not effective.

The service was not compliant with the MCA. This had substantially infringed on people's quality of life.

The level of training the provider deemed necessary for staff to fulfil their roles had not been met. Clinical staff had not received specialist training and their competency to practice had not been assessed.

People had mixed views on the quality of food provision. The mealtime experience for people was not consistent across the home and some people received little interaction from staff.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not consistently receive care and support that was respectful and maintained their dignity. Choice was limited and their independence not fully supported.

The service could not demonstrate that people had been involved in planning the care and support they received.

Although planned, care plans reviews had not commenced.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's basic needs were met but they did not receive care and support in a way they met their individual needs.

The social and leisure needs of those that used the service were not met. Information on people's lives, relationships and important events had not been recorded making it difficult for staff to build meaningful relationships with them.

The service had a complaints policy in place to address any concerns people may have. No complaints had been recorded since our last inspection.

Is the service well-led?

Inadequate

The service was not well-led.

A system was in place to monitor the quality of the service but this had failed to drive improvement or mitigate risks to people.

The provider was aware of the failures within the service but had not taken suitable and timely actions to bring about the necessary improvements. Concerns we had found during our April 2017 inspection had not been rectified.

There were not enough management resources in place to ensure a safe, effective and good quality service was being delivered.

Swanton House Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 7 and 9 August 2017 and was unannounced. Two inspectors, a medicines inspector, a specialist nursing advisor and an expert-by-experience carried out the first day of the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day of inspection was carried out by one inspector.

Before we carried out the inspection we reviewed the information we held about the service. This included statutory notifications that the provider had sent us in the last year. A statutory notification contains information about significant events that affect people's safety, which the provider is required to send to us by law. We also viewed the feedback we had received on the service from members of the public. Liaison with the local authority safeguarding team, the local clinical commissioning group and the local authority quality assurance team had also taken place leading up to the inspection.

During our inspection we spoke with nine people who used the service. We also spoke with the provider's director of governance and quality, the regional director, a consultant who had been employed by the provider in a clinical lead role, the deputy manager, an agency nurse and six support workers. In addition we spoke with three professionals who were visiting the service at the time of the inspection visits. Some of the conversations we had with people were brief. Following our inspection, we received additional information from a staff member. We observed care and support being provided to the people who used the service on both days. Following our inspection visits, the service submitted further records within the stated timescale.

We viewed the care records for 11 people who used the service. We also looked at the medicine administration records and associated documentation for a number of others. Records in relation to the management of the home were also viewed. These included staff personnel files, minutes from meetings held, staff training records, quality monitoring information and maintenance records.

Inadequate

Is the service safe?

Our findings

At our last inspection, carried out in April 2017, we found that the service had failed to do all that was reasonably practicable to mitigate the risks associated with people's health, wellbeing and medicines administration. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection in April 2017, an action plan was submitted by the provider which detailed how the service would meet their legal requirements. They told us that these actions would be completed by July 2017. At this inspection, carried out on 7 and 9 August 2017, we found that the necessary improvements had not been made and that the risks to people had increased since our last inspection. The provider was still in breach of this regulation.

The risks to those that used the service had not been fully identified, assessed or managed. We found that one person had self-harmed resulting in an injury that required medical intervention. This incident of self-harming had occurred when the person had become distressed whilst receiving support with their personal care. Whilst medical treatment had been sought by the service, they had failed to identify this as an ongoing risk to the person and act accordingly. No investigation had occurred and no assessment of the risk had taken place in order to help protect the person from future harm.

For another person, 12 incidents had occurred over a two month period that had resulted in distress, harm or potential harm to them or others. These incidents included occurrences of both physical and emotional harm. The associated care and risk management plans in place for this person gave staff little guidance on how to support them to remain mentally well and therefore reduce the risk of behaviour that may challenge or harm. It instructed that staff were to be responsive to early indicators that the person may be experiencing deterioration in their mental health. However, no information was recorded on how to recognise these early indicators and how staff could support the person to prevent this deterioration happening.

Furthermore, after each incident, little, if any, review and assessment had been completed in order to identify whether further actions were needed in order to reduce future risk. In addition, the staff we spoke with who were on shift at the time of the inspection and supporting this person, were not able to tell us how they provided care to this person to minimise risk and maintain safety and wellbeing. During our inspection we noted that there were times when this person did not receive the supervision they had been assessed as requiring in order to keep them, and others, safe. This put the person, and others, at risk of harm or serious injury.

For a number of other people living at the home, the risks associated with their nutritional health had not been effectively managed and therefore put them at risk. For two people who required a soft diet to reduce their risk of choking, we saw that the correct textured diet had not been consistently provided. During our inspection, we spoke with one of these people in their room. On entry, they told us they were thirsty and needed a drink. We noted that no fluid was available to them as instructed in their care plan. For a third

person, who had been assessed as at risk of losing weight and developing pressure areas, their care plan instructed that staff were to monitor their weight every two weeks. However, this had not happened. This meant that staff were not aware of the current risks to the person's health so that appropriate and timely actions could be taken if necessary. For a fourth person, their care plan stated that an assessment of the risk relating to their nutritional health was to be completed each month. This had not taken place. Consequently, the staff would not be aware if the person's nutritional health were to deteriorate.

We saw that reports had been completed when accidents and incidents had occurred. However, the provider had no system in place to effectively analyse, review and monitor these. During our inspection, no analysis was available to us and no staff member had an overview of, or took responsibility for, these. Therefore potential trends and contributing factors were not being identified and effectively reviewed in order to mitigate future risk of occurrence.

The risks to people were further increased due to the service's reliance on agency staff. During our inspection carried out in April 2017, the service had a stable and mostly permanent staff team in place who knew the people they supported and their associated needs and risks. At this inspection, completed in August 2017, the staff team was heavily bolstered by the use of agency staff which increased the risk of people not receiving care and support from staff who knew them, and their complex needs, well.

These concerns constituted a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Procedures were in place to help protect people from the risk of abuse. However, these were not effective as staff did not consistently demonstrate that they had the knowledge to identify, protect and prevent abuse. For example, a staff member had recorded on an incident form relating to a person who had self-harmed that this was 'normal behaviour' for that person when they experienced agitation. Whilst the incident form records what immediate treatment staff gave in response, the sections showing who the incident was reported to, both internally within the provider and externally, was left blank. The incident had not been identified as a potential safeguarding incident and therefore appropriate action had not been taken.

During our previous inspection, carried out in April 2017, not all staff understood the procedures relating to safeguarding people from abuse. This was because only 45% had received training in relation to this. At this inspection, carried out in August 2017, this figure was still only 61%. An action plan submitted to CQC, by the provider and dated 21 July 2017, stated that staff training was to be complete by the end of July 2017. In order to mitigate the risk associated with untrained staff, the action plan stated that, should this deadline not be achieved, then staff would be suspended from duties. However, this had not happened and we saw that, on the days of our inspection visits, eight staff members employed by the provider on a permanent basis were working who had not received this training.

The provider had failed to ensure staff received training in safeguarding matters and had not implemented processes to ensure that appropriate actions were taken when incidents occurred.

These concerns constituted a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at staffing levels within the service to see whether there were consistently enough staff to meet people's needs in a safe manner. Those people who were able to communicate their views about staffing levels told us there were consistently not enough staff to support them as and when required. One of these said, "I ring the bell, it depends how long [staff take to answer it], if it's lunchtime they wouldn't come. If it

was now, they would come more or less straight away. There are a lot of agency staff now as they are short staffed. The agency staff yesterday were marvellous however that doesn't happen every day. Some ignore you and try not to catch your eye." The second person told us, "Staff tend to leave us alone which can't be very informative for them. When they are here, they are only here in short bursts."

All of the care staff we spoke with, except one, had concerns over the staffing level's inability to meet people's needs in a person centred or safe manner. One staff member said, "Staff run around like headless chickens." This staff member also told us there was a delay in answering people's call bells due to lack of staff. They told us the service ran short of the levels instructed by the provider on a 'regular basis.' Another staff member said of the current staffing at the service, "Last few weeks have been quite unsettled." Another staff member told us that when people required dedicated one to one support this affected the staffing levels and their ability to meet people's needs. They told us it appeared that the provider made no provision for the extra workload this caused. We looked at the staffing rota for week commencing 31 July 2017 when one person required one to one support. This showed that, although the provider had made provision for an extra staff member to deliver this support, this had not happened consistently as required.

Shortly before our inspection, and shortly after it, we received information that also raised concerns about the staffing levels within the service, particularly in Holly Court. One reported a lack of staff to support two people who were becoming distressed on a particular day in July 2017. This person reported that there were minimal staff present to support people, particularly in the communal areas. Another person informed us of an incident that occurred in early August 2017 which put those people living at the service at risk. This person told us no staff were present at the time of the incident and, although no harm came to people, the risk was present due to lack of staff presence in a communal area.

Staff rotas for the week commencing 31 July 2017 showed that each unit ran short of the levels of staff the provider deemed necessary on at least two shifts.

These concerns constituted a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A member of the CQC medicines team looked at how information in medication administration records and care notes for people living in the service supported the safe handling of their medicines.

Records were in place to show people living at the service received their medicines as prescribed and to enable staff to monitor medicine administration records. However, the service recently informed us of incidents where it was suspected people did not receive their medicines as prescribed. During the inspection, we identified further gaps in records where they did not confirm that people living at the service had received their medicines when scheduled. We also found that when medicines were not given to people, records of the reasons why they were not given were not always accurately completed. In addition, whilst there were numerical audits in place to account for medicines, we noted these were not always accurately completed by staff and kept up to date.

Some supporting information was available for staff to refer to when handling and giving people their medicines. However, when people were prescribed medicines on a when required basis, there was sometimes no or insufficient written information to show staff how and when to give each medicine prescribed in this way to people consistently and appropriately. In addition, we noted that information that had been written had not been regularly reviewed.

Recent errors that the service had identified were being investigated and an action plan had been written.

Medication reviews for people living at the service had been arranged and started. Further training had been provided for staff currently handling and giving people their medicines and their competence had been assessed. Action was being taken to ensure there were further and sufficient members of staff trained and assessed as competent to give people their medicines. The action plan also included implementing weekly audits of people's medicines by a senior member of staff. However, during the inspection, the service confirmed to us that due to staff absences, an audit had not been carried out for 18 days.

The risks associated with the premises had been identified, assessed, managed and reviewed. Regular maintenance checks had taken place which included the regular servicing of equipment, the monitoring of the firefighting systems and checks completed to reduce the risk of Legionella bacteria within the water system. The provider also had a business continuity plan in place in the event of adverse incidents. Processes were also in place to reduce the risk of employing staff not suitable to work in the service. The staff recruitment files we checked, confirmed that this process was being adhered to.

Inadequate

Is the service effective?

Our findings

At our last inspection, carried out in April 2017, we found that the service had failed to comply with 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.

Following our inspection in April 2017, an action plan was submitted by the provider which detailed how the service would meet their legal requirements. No timeframe was given for the completion of these actions. At this inspection, carried out on 7 and 9 August 2017, we found that the necessary improvements had not been made. In addition, we found that the provider's failure to meet this regulation had significantly infringed on people's rights and quality of life. The provider was still in breach of this regulation.

The 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 Act 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. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We looked at the care plans and associated documents for three people who used the service who had had DoLS authorised. We also spoke with an independent MCA advocate. We saw that for all three, the service had failed to adhere to the MCA and therefore protect and empower people. This was because the conditions attached to the DoLS authorisation had not been met.

For one person, conditions attached to their DoLS authorisation stated that a best interests meeting was to take place to consider whether medicines needed to be administered covertly. It stated this meeting was to include the GP and family members and that the consultation needed to be evidenced in the care plan and medicines administration record. A further condition stated that the person's capacity to make this decision, and the need for covert medicines, was to be reviewed on a monthly basis and evidenced in their care plan. This had not happened. The care plan and associated records contained no records as required by the conditions. We discussed this with the deputy manager who confirmed these conditions had not been met and that no records were available.

For another person, the conditions attached to their DoLS authorisation had been put in place in order to assess whether it was possible for them to live closer to a person who was important to them. The conditions instructed that the service was to record information about the risks associated with this potential move and how the service managed and mitigated those risks. Furthermore, the conditions instructed that all contact arrangements for the two people, be recorded. This documentation was to

include details of how successful this contact had been or the reasons for the planned contact not being made. The care planning documents we viewed demonstrated that this had not been completed as stipulated by the DoLS authorisation. This failure had jeopardised this person's opportunity to be with a person important to them.

The conditions and recommendations attached to the authorised DoLS application for a third person had also not been met. These requested that, subject to a risk assessment, the person was to have increased access to the garden. Conditions also requested that a care plan be implemented in relation to this. Furthermore, it instructed that records were to be kept in relation to when this person used the garden and when this was refused. The care records we viewed for this person showed that these conditions had not been fully met.

The independent MCA advocate we spoke with told us they had concerns in relation to how staff supported those they advocated for in relation to their DoLS conditions. They said, "I'm just not seeing what I need to see." They explained that conditions were not being met and that, despite requesting robust documentation be put in place in relation to people's DoLS conditions, this had not happened.

These concerns constituted a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had assessed people's capacity to make decisions, including those associated with the above DoLS. However, the assessments often lacked detail to describe the steps the service had taken in order to fully support people to make decisions and their rationale for the actions taken. Most staff had received training in MCA and DoLS. However, the service could not demonstrate full compliance with the MCA.

Between the first and second visits of our inspection, the service had taken some action to rectify their failure to meet the above conditions. However, at the time of our inspection, the DoLS had been granted for several weeks in each instance and people's quality of life had already been significantly infringed.

During our inspections carried out in December 2016 and April 2017, we found that staff were not always properly trained to meet the specific needs of the people they supported. The management team were aware of this at the time of both inspections and told us that they were addressing this issue. However, at this inspection, carried out on 7 and 9 August 2017, significant gaps remained in the training the provider considered as core training areas. Sufficient improvement had not been made in an appropriate timescale and this put people at risk of receiving care, support and treatment not appropriate to their needs.

In April 2017, the overall compliance rate for staff training was 45%. At this inspection, carried out in August 2017, this had increased to 64%. However, this meant that 36% of staff employed were not fully trained to perform their role to the level the provider deemed the minimum standard. Whilst the provider had some training sessions booked, at the time of the inspection low compliance levels of staff training were evident. For example, only 28% of staff had received training in incident reporting. This was particularly concerning given that serious concerns were identified at this inspection in relation to incident management. At our inspection in April 2017, we reported that only nine staff had received training in effective communication. At this inspection, carried out in August 2017, this had only increased to 33 staff out of the 88 employed. Only 54 staff had received training in safeguarding vulnerable adults.

As found at our inspection in April 2017, we again found that those staff employed in a clinical role had not had their competency to practice in specialised areas assessed or reviewed, except in regards to medicines administration. Since our inspection in April 2017, we saw that little clinical training had been delivered and

clinical staff still fell short of the level deemed appropriate by the provider. The lack of up to date training and assessment of clinical competencies increased the risk that people could receive care and support that was not in accordance with best practice.

These concerns constituted a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of our inspection, some staff had been moved around the units of the home. Whilst we understood that this was to ensure flexibility and to meet the needs of the service, staff had not always received the support required to get to know the people who used the service, their needs and preferences. One staff member told us that they had not had time to view care plans and that they had not felt prepared to support people following the few job shadowing shifts they had received. Through discussions with two other staff, it was clear that they did not know the needs of those they were supporting. Whilst the records we viewed showed that staff supervision sessions had been booked for the rest of the year, they also showed that 42% of staff had not received any so far this year.

We asked four people who used the service for their views on the food provision. We received a mixed response. One said, "For dinner you have an option. All the meals here are brown." The second person told us, "I get all my meals prepared for me…the food is very basic, I do get fruit and biscuits though." However, the two other people we spoke with were happy with the quality of meals served. One said, "The food is excellent" whilst the other told us, "I've never had a bad meal here."

During our inspection, we observed lunch being served in all three units of the home. We saw that menus were on display in each unit that showed people had a choice in what they had to eat and drink. However, we found that the quality of service, staff interactions and the experience people had varied across the units. In one unit, we saw that although people received their meal fairly promptly and together as a table, the staff member delivering people's meals did not interact with the people they were serving at all. When one person asked another staff member what was for dessert, they said they did not know and made no attempt to find out for them. Throughout lunch being served, we saw that there was little interaction from staff and the atmosphere was functional and flat within this unit.

On another of the units, we saw that the lunchtime provision was better. We saw that people received the dedicated support they needed and that the staff interactions were reassuring and respectful. Where people were receiving assistance to eat, we saw that staff explained what was on the fork and were patient and paced. On all the units, we saw that the food was well presented and varied to suit individual's needs and preferences.

However, some people had not consistently received the specialist diet they required which had put them at risk. Furthermore, one person we spoke with told us they were thirsty and needed a drink. We saw that no drink was available to them and that the need to ensure the person had access to fluid within their room, as their care plan stipulated, was not in place.

People had access to healthcare provision and records showed this had been received by people. Referrals had been made to appropriate health and social care professionals however outcomes were not always recorded meaning tracking someone's health and wellbeing would be difficult. For example, one person had been receiving support from a dementia specialist team however regular entries on the progress of this had not been made.

Requires Improvement

Is the service caring?

Our findings

The people that used the service told us that they were not consistently treated with kindness and respect by staff. They told us they felt overlooked and that staff did not have time for them or support them to feel empowered.

One person who used the service told us, "The staff here don't take much notice when you speak to them. I might ask for something but they ignore you." Another said, "Some staff are horrible, ordering me about. The night staff used to say you will have to wait and do as you are told but recently I have found it easier to wait for a drink at night." A third person explained, "Most of the staff I see are friendly, a bit patronising, pat on the head, there, there. There are good staff and bad staff. I don't like being thought of as stupid." This person went on to say, "Like most humans, I like communication and I don't get enough of that. I guess I feel under rated." When we asked a fourth person whether staff came to talk with them, they answered, "No."

During our inspection visits, we saw examples of staff's approach that demonstrated a failure to treat people with dignity, respect or compassion. Whilst this didn't apply to all members of staff, we saw that there was a culture in place that had normalised this approach. For one person, we saw that they waited 45 minutes for their lunch whilst staff assisted another person. During this time, little interaction occurred and the person was mostly ignored. On another occasion we saw a staff member put a hot drink and a biscuit down on a table for another person. No interaction occurred and the person was not asked whether they wanted what was being provided. The staff member did not use any warm or engaging facial expressions during the interaction. In addition, we saw people having clothes protectors put on them without their consent first being sought.

One person required personal care whilst in a communal area. Whilst we saw that staff assisted this person without delay, it was not done discreetly and further staff actions drew attention to the person. This did not maintain the person's dignity and did not demonstrate respect or empathy in how the person might be feeling. For another person who required assistance with their mobility via the use of equipment, we saw that staff did not engage with the person at all during this care intervention.

All staff had not demonstrated a caring, compassionate and respectful approach when caring for, and supporting, people. People's dignity had not been maintained and communication was not consistently respectful.

These concerns constituted a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff we spoke with did not consistently demonstrate that they knew the people they were supporting. Not all staff could tell us people's needs, likes, preferences and the risks associated with their care and support. We asked two staff members to explain what care and support one person needed who showed regular incidences of distress and escalating behaviour that challenged them and others. Neither were able to tell us how this was being managed and what recent professional interventions had occurred to support

the person. Whilst another staff member was able to tell us the basic care needs of another person, they were not able to give us any information on the person's likes, family circumstances or life history.

A health/social care professional we spoke with told us they had concerns that not all staff knew the needs of those that used the service meaning it was not possible for them to fulfil their role effectively. They told us the service had failed to provide them with a staff member that was able to give adequate information on the person they were supporting. This professional told us they also had concerns that the staff had failed to identify that the person had lost weight. They said, "It was just like they hadn't even noticed." A second health/social care professional agreed that no staff were available who fully understood the needs of the person they needed to discuss.

There was no evidence that demonstrated people were involved in their plan of care and support. People were unable to tell us whether they had been involved and care plans did not demonstrate that people, or their relatives, had had input. As part of an action plan in place for the service, it recorded that care plan reviews were to take place for all people who used the service, with those that represented them as required. However, at the time of this inspection, this had not commenced.

People were not able to fully tell us if they were offered choice in their day to day routines and care plans did not specifically account for this. During our inspection, we saw staff offering some choice to people in their day to day activities although this was not consistent amongst all staff. However, choices around activities and leisure activities were restrictive.

The support people needed in regards to maintaining their independence was considered in their care plans however we had concerns that there were not consistently enough staff to fully support people with this. One person who used the service told us, "I can walk with a frame. I do that sometimes. What I do is walk to the garden with someone. I don't do it very often, they always say they are short staffed. That's always the excuse."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, carried out in April 2017, we found that people did not receive care and support that was individualised and specifically personalised for them. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection in April 2017, an action plan was submitted by the provider which detailed how the service would meet their legal requirements. They told us that these actions would be completed by July 2017. At this inspection, carried out on 7 and 9 August 2017, we found that the necessary improvements had not been made and that the provider was still in breach of this regulation.

People's basic care needs were met but they did not receive a person centred service or one that was designed individually for them. Staff supported people in a task orientated manner. One person told us how the service failed to meet their spiritual needs. They said, "What annoys me is on Sundays. I am committed to my faith and I want to go to church. They say they can't take me as they don't have enough staff." Another person told us, "My basic needs are met; food and I do have my own place here and I do know that if I get confused I can ask for help. There are some I can't ask, they would be dismissive, they've been that to me and I've seen them do it to other people. That's not doing their job."

Another person who we spent time with had the radio on in their room. We asked them if they liked having it on and they told us they didn't but that staff put it on anyway. We saw in this person's care plan that they had a specific interest that would be easy to meet each day. However, this wasn't being met and a professional we spoke with agreed that they had never witnessed this need being met whenever they visited. Whilst there was no indication that staff were putting the radio on against the person's wishes, no one had spent the time to discuss this with them and discover that they did not always wish for it to be on.

The care plans we viewed varied in terms of the amount of information recorded, how accurately they reflected people's needs and how often they had been reviewed. Some people had a one page profile which would help staff unfamiliar with the person see at a glance how to support them. There was also a care plan in place for each area of need and although these contained person centred information, we did not see that these needs were consistently met. For example, for one person, their care plan documented a specific need that was recorded as important to them. We checked to see whether this was being met and saw that, on the day of our inspection, this was not in place.

Care plans contained very little, if any, information on people's life histories, likes, dislikes, family circumstances, important relationships and aspirations. Lists were contained within care plans of activities people may like however this was a tick list and gave no scope for anything meaningful to be recorded. This lack of information on who each person was, their history, what was important to them and what their aspirations were made it difficult for staff to build relationships with people.

People told us that their social and leisure needs were not met. Some people told us they did not have enough to do. One person who used the service told us, "Boredom is my main problem. Every day is the

same. I never did like group or communal activities." This person went on to say, "I do feel I have experience and talents that are wasted here." Another person said, "I spend every day here." A third person told us that although they did little, they had an active mind which kept them from being bored and lonely.

Most of the staff we spoke with agreed that the service did not provide enough opportunities for people to socialise or go out. One staff member told us there were not enough staff in place to take people out and that people's environment remained the same as a result. When we asked another staff member if they felt there were enough activities for people, they said, "Probably not. Staff do as much as they can though." A third staff member told us, "People don't go out because we don't have enough staff."

During our inspection, we saw little activity taking place and little choice offered in how people had their leisure and social needs met. We saw that interactions were often brief and functional. Most people spent the day in front of the television or in their rooms.

These concerns constituted a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had an action plan in place to address the concerns raised around their failure to provide person centred care which was identified at our last inspection carried out in April 2017. However, these actions had not been completed and people were still receiving care that was task orientated and not designed around them as individuals. This aspect of the service, together with an increase in the use of agency staff, meant the risk to people not receiving a person centred service remained.

The service had procedures in place to manage any complaints people may have. We saw that the complaints policy was visible within the home. No complaints had been recorded since our last inspection.

Inadequate

Is the service well-led?

Our findings

At our last inspection, carried out in April 2017, we found that the provider had failed to implement effective systems to assess, monitor and improve the quality of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection in April 2017, an action plan was submitted by the provider which detailed how the service would meet their legal requirements. They told us that these actions would be completed by July 2017. At this inspection, carried out on 7 and 9 August 2017, we found that the necessary improvements had not been made and that the provider was still in breach of this regulation.

The systems the provider had in place to assess, monitor and improve the quality and safety of the service had continued to fail. No registered manager was in place at the home and the provider had employed a consultancy agency to manage the home six weeks prior to this inspection. This had resulted in the consultants dealing with immediate issues only and replicated what we found at our inspection carried out in April 2017. Each unit of the home was being led by either a senior support worker or nurse. At the time of this inspection, a robust overview of the service had not been formed by the consultants and no single member of staff had this view of the service. None of the three units had a manager in place and the deputy manager had started in their role on the first day of our inspection visit. The instability of the management team had continued to have an adverse impact on the service people received.

Following our inspection carried out in April 2017, an action plan had been implemented specifically targeting the issues found at that inspection. However, at this inspection carried out in August 2017, few of the actions had been completed with the majority not having commenced. For example, care plan and daily management audits had not been completed as agreed, the staff training deadline date missed and positive behavioural plans not written. The provider's quality assurance system had been reviewed but not fully implemented at the time of this inspection. Few audits had taken place. Therefore few areas of the service were being monitored or assessed for effectiveness or safety. Concerns were evident across the service as highlighted in this report.

Only one provider visit report was available to us following a compliance visit made to the service, by a senior manager, on 6 July 2017. This had been undertaken to assess the progress made by the service following the identified concerns at the inspection in April 2017. It identified a number of concerns that were still evident at this inspection. For example, lack of activities and stimulation for people, poor care documentation and action to resolve this, lack of staff, poor interactions from staff and a poor lunchtime experience. It also stated that, due to excessive annual leave being authorised across the whole service, this was impacting on the service's ability to release staff for training. However, the visit failed to review risk management and the service's compliance with the MCA, both of which had been identified as areas of concern at our inspection in April 2017.

After this inspection carried out in August 2017, we were supplied with further information. This demonstrated that the provider was aware of the serious concerns found at the service, specifically in

relation to the management of people's mental health and associated challenging behaviours.

Since our last inspection in April 2017, little feedback had been sought on the quality of the care and support provided from those that used the service, their relatives or staff. One meeting had taken place in July 2017 for those that used the service and their relatives but minutes were not available to view. Questionnaires had recently been sent out but results were not yet available at the time of this inspection. Some staff meetings had taken place where identified concerns were discussed.

As part of their quality monitoring system, the provider asked people who used their services to visit the homes of others within their ownership. These visits were entitled a 'quality expert observation' visit and were implemented in order to complete a quality review and drive improvement. However, none had taken place since March 2017 and this further demonstrated the provider's failure to ensure effective quality monitoring systems were in place.

The effectiveness of staff was inconsistent due to the use of agency staff and the impact this had on permanent members of staff. Whilst actions had been taken to ensure agency staff had the basic skills and training to perform their role, they did not always have the experience or information to support the very specific and complex needs of those living at Swanton House Care Centre. This was because care plans were variable in the information they contained and simply as agency staff had not had time to get to know the needs of those that used the service.

Staff morale amongst permanent staff was variable across the units. One staff member told us that they did not feel valued or appreciated or empowered to make suggestions. Another felt concerned and unsettled. A third felt let down by some of their colleagues whilst another told us they had been 'ignored' on their first day in post. However, this staff member told us this had improved over time.

These concerns constituted a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

It was clear that the service continued not to have enough management resources in place to drive the improvements required and to ensure a safe, consistent and good quality service was delivered. The instability of the management team had continued to have an adverse impact on the service and, at the time of the inspection, the consultancy agency the provider had employed had not had enough time to drive improvement. The units of the home continued to work separately and this had not aided the effectiveness of staff when they had been moved around the units. Nor had it aided continuity, monitoring or the analysis of information in order to mitigate risks and make improvements.

Whilst the provider had continued to identify concerns at the service as highlighted in this report, required improvements had not been made in an adequate timeframe and issues were still present. We have serious concerns about the health, safety and welfare of people who use the service and the provider's ability to mitigate the risks associated with this.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The service had failed to implement effective systems to assess, monitor and improve the quality of the service. Regulation 17 (1) (2)(a)(b)(c)(e) and (f)

The enforcement action we took:

Urgent NoD to impose conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough sufficiently competent and skilled persons employed to meet people's needs. Regulation 18(1) and (2)(a)

The enforcement action we took:

Urgent NoD to impose conditions.