CareQuality Commission

Phoenix Residential Care Homes Limited

Phoenix Residential Care Home

Inspection report

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

Summary of findings

Overall summary

About the service
Phoenix Residential Care Home is a residential care home providing personal care to 13 people aged 65 and over at the time of the inspection. The service can support up to 18 people in one adapted building.

People's experience of using this service and what we found
Very few improvements had been made since the last inspection. The service provided to people continued to not be good.

Plans were not in place to keep people safe from fire risks. Individual risks were not always assessed and managed to keep people safe. People could not be assured the numbers of staff on shift were sufficient to provide the individual care needed to support their safety, health and well-being.

The premises were not clean in all areas and plans had not been put in place to make sure people were living in a service that was kept clean and free from odours. People were not supported to have a homely and individual bedroom to create a pleasant and personal environment.

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.
Staff had received training to meet people's needs. There were concerns about the effectiveness of the training given.

Although people's care plans had improved, providing more detail and personal information, there continued to be areas that needed to improve to make sure people received care and support in the way they wanted and needed. People were still not provided with the motivation and opportunity to follow their interests or offered meaningful occupation to prevent social isolation and maintain their well-being.

The management and oversight of the service was still not robust enough to identify areas of concern and put actions in place to continuously improve quality and safety. The provider had not updated their own training. Only few improvements had been made since the last inspection and this was a cause for concern. This was the seventh inspection where the provider had not achieved a rating of good and the third consecutive rating of inadequate.

Staff continued to receive regular individual support meetings and the provider held regular staff meetings to keep staff up to date. Staff recruitment continued to be managed safely.

People and their relatives had not made any complaints since the last inspection. At the last inspection, the provider had not appropriately dealt with complaints received. People were still supported well at the end of their life, although their wishes were not recorded well. This is an area for improvement. People's

medicines were now managed safely.

Staff knew people well and spoke about them in a caring and compassionate way. We saw caring interactions between staff and people.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 4 September 2019). At this inspection enough improvement had not been sustained and the provider was still in breach of regulations.

This service has been in Special Measures since 13 March 2019. During this inspection the provider demonstrated that enough improvements have not been made. The service continues to be rated as inadequate overall. Therefore, this service continues to be in Special Measures.

Why we inspected
This was a planned inspection based on the previous rating. This inspection was carried out to follow up on action we told the provider to take at the last inspection.

Enforcement
We have identified six continued breaches in relation to safe care, staff deployment, suitability of the premises, consent and decision making, person centred care and quality monitoring, management and leadership, at this inspection.

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.

Since the last inspection we recognised that the provider had failed to display their ratings on their website. This was a breach of regulation and we issued a fixed penalty notice. The provider accepted a fixed penalty and paid this in full.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? 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 caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well led. Details are in our well led findings below.	**Inadequate**

Phoenix Residential Care 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.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Phoenix Residential Care 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. The registered manager was also the provider. This means that they 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 on the first day and we told the provider when we would return to complete the inspection.

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 who work with the service, and the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and

social care services in England. We used the information the provider sent us in the provider information return. 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. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and one relative about their experience of the care provided. We spoke with seven members of staff including the provider, the deputy manager, the care manager, team leader, care workers and kitchen staff.

We reviewed a range of records. This included three people's care records and many medication records. We looked at one staff file in relation to recruitment and staff supervision. A variety of records relating to the management of the service including monitoring and auditing records were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and information about fire safety precautions.

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 inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection, the provider had failed to robustly assess the risks relating to the health, safety and welfare of people in a number of areas. These included individual risks around moving and handling, nutrition and hydration, pressure areas, medicines management and fire risks. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took enforcement action against the provider which has not yet been published. Full information about CQC's regulatory response is added to reports after any representations and appeals have been concluded.

At this inspection, although some improvements had been made in some areas, we found the assessment of risk was still a serious concern. The provider was still in breach of regulation 12.

● Although some improvements had been made to identifying and managing individual risks there continued to be a lack of understanding of how to keep people safe. For example, one person was given toast for breakfast while they were still lying in bed. Staff had left them to eat alone, lying flat, with the plate of toast on their chest and a beaker of tea in their hand. They were unable to move themselves into a sitting position and so were at risk of experiencing difficulties, including choking. We asked a member of staff to move the person to enable them to safely eat their breakfast. The staff member was not concerned the person was left lying flat to eat and was unaware this was a risk. There had not been an incident of choking, however, specific staff training how to avoid incidents of choking had not been undertaken.
● We found serious concerns around people's safety in the event of a fire. After the last inspection, CQC requested the Fire and Rescue Service (FRS) visit to undertake an inspection of the premises. A fire risk assessment by a specialist company had been carried out prior to the FRS visit. The majority of recommendations in the fire risk assessment to improve fire safety had not been completed. The requirements set out by the FRS in October 2019 to meet regulations had not been completed. Most of this work was not the responsibility of the provider, but the building owner. However, the provider had not taken any action to ensure people's safety while waiting for the work to be completed. For example, the required work included replacing the fire alarm system and all fire doors. People were not safe in the event of a fire as the systems and protection to keep them safe were faulty. A plan had not been put in place to protect people.
● Evacuation procedures had not been reviewed in response to the current risks.There were no records to evidence a fire evacuation drill had taken place since the FRS visit. Individual personal emergency evacuation plans (PEEP) had not been reviewed to make sure people could be evacuated safely, taking account of the reduced fire safety. People's needs had not been re assessed and staffing levels had not been

considered, particularly overnight when only two staff were on duty. After raising our concerns, the provider arranged a staff sleep in shift to support safe evacuation overnight until the fire safety work was complete. They reviewed their evacuation procedure and PEEP's during and after the inspection following our concerns.
● One person's individual risk assessment identified a known risk around the ingestion of liquids, such as toiletries kept in their bedroom. The record said the person's toiletries must be kept in the cabinet in their en-suite bathroom as they were unable to open this. The liquids had been on the open shelf on both days of inspection. We alerted the provider who immediately removed the items. They were unsure how long the hazardous liquids had been present on the shelf and not safely put away. Even though this was a serious hazard and known risk, monitoring systems were not in place to keep the person safe.
● There continued to be some safety concerns around the premises. Some doors we found unlocked at the last inspection, posing a health and safety risk were now locked. However, an airing cupboard was unlocked. Hot pipes were accessible in the cupboard which posed a burns risk to people if they touched or fell against them. The provider locked the door when we told them. Venetian blinds were in place in the communal conservatory. The blinds were open during the inspection and the pull cords were hanging down, which posed a hazard to people's safety as they may become entangled. This was raised as a concern at the last inspection. We raised our concerns with the provider and action was taken to wind the cords into a safe position by the time we arrived on the second day of inspection

The failure to ensure risks were robustly identified and managed to prevent harm so people received safe care is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's care plans had been fully reviewed since the last inspection and some individual risk assessments were now in place for known and ongoing risks. One person was at risk of malnutrition at the last inspection and had a low and declining body weight. They continued to have a poor appetite and were still at risk of malnutrition. However, the risks had been identified and assessed and clear guidance was in place for staff and the person had gained weight.

Staffing and recruitment

At our last inspection, the provider had failed to ensure staff were deployed so people's care needs and preferences were met. Concerns included, people being consistently left in bed until late morning, and staff not having time to meet people's social needs or to keep the premises clean. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took enforcement action against the provider which has not yet been published. Full information about CQC's regulatory response is added to reports after any representations and appeals have been concluded.

At this inspection, enough improvement had not been made to the planned deployment of staff. The provider was still in breach of regulation 18.

● Staffing resources were not used to their best advantage to provide a safe service. Important tasks were not allocated to make sure they were completed. The provider told us they were responsible for cleaning the service, however, they did not have time to do this effectively. A plan was not in place to ensure the cleanliness of the home. People could not be assured staff were available to meet their needs as clear plans were not in place to allocate tasks.
● Staff continued to be task orientated around people's care needs and record keeping. Time was not made available to ensure people's social needs were met. People were at risk of social isolation and were not

supported with activities.
● The team leader who was due to be on shift on the first day of inspection had left suddenly two days before. Team leaders were responsible for leading each shift, which included administering medicines. The provider had stepped into this role at short notice as staff on shift were not trained to administer medicines. When other members of the management team arrived on duty, the provider did not consider allocating other team leader tasks to make sure staff were suitably deployed to appropriately meet people's needs.
● There were shortfalls in staffing on the rota which meant that enough staff had not been identified to be on shift to meet people's needs. The rota showed three days over the next week, including the next day, where enough staff were not identified on the rota. The provider sorted this out and covered the shifts during the inspection.
● Previously a dependency assessment tool had been in use to identify people's needs and the staffing resources required to meet them. However, the assessments had not been completed since October 2019, to check people's changing needs and make sure the correct numbers of staff were available. One person had been in hospital at that time and a new assessment had not been completed on their return.

The failure to ensure staff were deployed so people's care needs and preferences were met is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The staff vacancy created by the team leader leaving meant shifts needed to be covered. Staff said they would do what they could to help out. One staff member said, "People come first. I need to know they are ok."
● Staff continued to be recruited safely. Application forms were completed with no gaps in employment, references and proof of identification were checked. Disclosure and Barring service (DBS) checks had been completed which helped prevent unsuitable staff from working with people who could be vulnerable.

Preventing and controlling infection

At our last inspection, the provider had failed to ensure the service was visibly clean, free from offensive odours and properly maintained. This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took enforcement action against the provider which has not yet been published. Full information about CQC's regulatory response is added to reports after any representations and appeals have been concluded.

At this inspection, although improvements had been made in some areas, there were still areas of concern. The provider continued to be in breach of regulation 15.

● At previous inspections, a very strong, overpowering odour was present in one person's bedroom. At this inspection, this had improved and there was no longer an odour in this person's bedroom. However, an underlying odour continued to be present in some areas, even though the provider said they were cleaning the carpet regularly.
● Alternative arrangements were not made to cover cleaning duties at the times the provider was unable to do these. Some areas of the service continued to not be clean, with layers of dust in communal bathrooms and people's bedrooms. Cleaning schedules had not always been completed to show daily cleaning had taken place, so it was unclear how often cleaning was carried out. For example, in November 2019 cleaning schedules evidenced cleaning was carried out on nine days, and in December 2019 only seven days. We asked the provider and were told these were the days that cleaning was completed.

The failure to ensure the service was visibly clean and free from offensive odours is a continued breach of

Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The laundry room was a serious concern at the last inspection as it was unclean and in disarray. At this inspection, the provider had made a number of changes and people's laundry was now well organised and laundered in a clean space.

Systems and processes to safeguard people from the risk of abuse

● The staff we spoke with were able to describe what abuse was and which organisations to contact if they had concerns. Staff told us they were sure the provider would deal with any concerns straight away.
● The provider knew their responsibilities to report any concerns to the appropriate authorities. Although no concerns had been reported since the last inspection, the provider had previously reported concerns when necessary.

Using medicines safely

At our last inspection, the provider had failed to ensure people's prescribed medicines were managed in a safe way. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took enforcement action against the provider which has not yet been published. Full information about CQC's regulatory response is added to reports after any representations and appeals have been concluded.

At this inspection, the provider had made improvements and people now received their medicines safely. The provider was now compliant with this part of regulation 12.

● At the last inspection, people did not receive their medicine on time and correctly, as prescribed. This had improved and medicines were now managed safely. Staff checked the medicines regularly to make sure the numbers left in stock tallied with the what had been signed as given in the medicine administration records.
● Medicine was ordered, stored and disposed of safely. Medicines administration records were complete with no gaps or errors in recording.
● There was information for staff about people's medicine such as why the medicine had been prescribed and how people liked to take their medicines. A member of staff described how they supported one person who did not always want to take their medicines, "I just go back a few minutes later and try again. With a bit of reassurance and just chatting they will usually take their medicines without a problem. (Person) lives with dementia and I just see how they are and change my approach."
● When people had medicines prescribed 'as and when necessary' such as pain relief, information was available for staff. The guidance included, why the medicine was prescribed, when the person may need to take it and what the safe numbers to take within a 24-hour period were.

Learning lessons when things go wrong

At our last inspection, the provider had failed to ensure lessons were learnt from incidents, so people received care that continued to be safe. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took enforcement action against the provider which has not yet been published. Full information about CQC's regulatory response is added to reports after any representations and appeals have been concluded.

At this inspection, improvements had been made and the provider now monitored accidents and incidents.

The provider was now compliant with this part of regulation 12.

● Accidents and incidents were recorded by staff on the appropriate forms. The provider checked the forms to make sure they were completed correctly. They now monitored incidents to identify themes and put action in place to learn lessons and prevent further occurrences.
● Care plans and risk assessments had been updated to provide staff with guidance to prevent further falls by learning lessons from the circumstances of the recent falls. One person had moved bedrooms. When they had a fall following this move, the provider identified this may have been caused by the configuration of the bedroom furniture being different. They moved the bed, so it was in a similar position to their previous room. Their unsteadiness improved.

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 the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Supporting people to eat and drink enough to maintain a balanced diet

At our last inspection, the provider failed to ensure risks to people's health were robustly identified and managed to prevent harm, so people received care that was safe. Concerns included close monitoring of people's weight loss and people not being encouraged and supported to eat and drink sufficiently at regular intervals. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took enforcement action against the provider which has not yet been published. Full information about CQC's regulatory response is added to reports after any representations and appeals have been concluded.

At this inspection, although some improvements had been made, there were still areas of concern. The provider continued to be in breach of regulation 12.

● One person was not engaging well with staff and spent their time in their room. They were at risk of dehydration and had a fluid chart in place and a daily fluid intake target. They had a catheter in place, so it was crucial they maintained a healthy fluid intake due to the risk of infection. The person's fluid balance charts showed poor fluid intake on most days, some days less than half the target intake.
● Each team leader on duty checked daily records were appropriately completed at the end of their shift. A record was made the person was regularly not drinking enough fluid, but no action was recorded as taken. A member of the management team completed a weekly audit. The managers audit did not record any concerns regarding people's fluid intake. There was a potential risk of dehydration, and monitoring processes were not effective in identifying this.
● Monitoring processes did not provide assurance that where people had nutrition and hydration risks, these were closely monitored to maintain health and well-being.

The failure to ensure risks to people's health were closely monitored to prevent harm is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people at the last inspection had not been appropriately supported and encouraged with a poor appetite and motivation. One person was now eating better and had gained weight.
● People could choose from two options on the menu but could ask for something different if they wished and this was catered for. The cook and staff were aware of people's likes and dislikes and the special diets or food consistencies some people were advised to have. Such as diabetic diets or soft foods. The cook told us

they had access to the food they needed to prepare people's meals, "I never have a shortage of anything. People eat really well. If I want something I just tell (provider) and she gets it."

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

At our last inspection, the provider failed to ensure the premises were suitable for the purpose it was being used. Concerns included, maintenance issues not rectified, worn and torn carpets and the need to update the premises. This was a breach of regulation 15 (Premises and equipment)) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took enforcement action against the provider which has not yet been published. Full information about CQC's regulatory response is added to reports after any representations and appeals have been concluded.

At this inspection, some improvements had been made, however there were still areas of concern. The provider continued to be in breach of regulation 15.

● Although maintenance issues continued to be evident around the service, the provider had made some improvements. The bench in the smoking area for people was now safe as it had been replaced. Some carpets that were previously torn and frayed had been replaced.
● The smoking area had not yet had a covered area installed to keep people safe from poor weather such as wind and rain. The provider told us staff supported people to go to another area further down the garden where a shelter was available, if the weather was poor. This was a further distance and the mobility of some people was deteriorating. This meant this may not continue to be a sustainable solution for some people.
● Many peoples bedrooms were bare and impersonal, with no pictures on their walls or personal items. No attempt had been made to support people to create a homely, relaxing, personal environment. Bedding was faded and sets of bedding did not match. For example, different colour and style of pillowcases to bedding covers
● The service continued to need updating to provide a more pleasant environment for people to live in. No further decorating had been completed since the last inspection. The provider told us they had purchased some new signage and intended to put this in place when decorating was complete. However, in the meantime, communal areas were still not dementia friendly and further work had not been carried out to the layout, décor and flooring.

The failure to ensure the premises is suitable for the purpose it is being used is a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

At our last inspection, the provider had failed to make sure people's basic rights were upheld within the principles of the MCA. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took enforcement action against the provider which has not yet been published. Full information about CQC's regulatory response is added to reports after any representations and appeals have been concluded.

At this inspection we found no improvements had been made to assessing people's capacity and making sure decisions were made in their best interest. The provider was still in breach of regulation 11.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. 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. 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Where people had a DoLS authorisation, this was not clear in their care plans. This meant staff may not have the information they needed to understand people's legal status and make sure their rights were upheld. One person had three conditions of their DoLS authorisation. One condition had been met but the other two had not. For example, a person's care plan, in relation to their social isolation, should be reviewed to see if any further support could be given to reduce this risk. The person's activity care plan did not refer to this condition and their daily records did not evidence that the person was receiving support to prevent social isolation.
● Another person had a DoLS authorisation in place with one condition, in relation to ensuring a care plan was developed for staff to support them with daily physiotherapy exercises. We could find no evidence of this. The provider said this was a mix up and the person did not have physiotherapy exercises to do, although they had seen a physiotherapist. However, the provider was unaware that this condition had been placed and therefore had not followed it up with the DoLS office.
● At the last inspection we found relatives signed people's consent forms with no explanation why they had been asked to. At this inspection, some consent forms had been reviewed and people had signed their own consent. However, others had not been changed. Evidence that relatives had Power of Attorney for health and welfare decisions had not always been sought to check they had the authority to make decisions on behalf of people.
● Where people were assessed as lacking capacity to make specific decisions, such as consenting to staff administering their medicines, a best interest decision making process had not always happened. For example, where people had been assessed as lacking the capacity to consent to staff administering their medicines, or to a flu vaccination, a record had not been kept of how these decisions were made in the person's best interest.

The failure to ensure people's rights were upheld within the basic principles of the Mental Capacity Act 2005 is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

At our last inspection, the provider had failed to make sure staff had received the training and development to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took enforcement action against the provider which is going through due process and not yet been published.

At this inspection, although some improvements had been made, the provider continued to be in breach of regulation 18.

● At the last inspection, staff had not received training to support people appropriately when their behaviour challenged or diabetes awareness training. New staff had not received training since joining the

service. At this inspection, staff had now completed mandatory training. Two new staff had started in post since the last inspection. They had both completed the necessary training since starting.
● The provider had completed training in how to deliver training to staff. However, they had not updated any of their own mandatory training. This meant the training they delivered to staff may not include the most up to date guidance and best practice. We found concerns around staff practice during the inspection, such as how to prevent choking and supporting people to maintain their rights under the Mental Capacity Act.

The failure to ensure staff had the appropriate training to ensure people's needs were met is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were supported in their role through one to one supervision sessions with a member of the management team. Staff responsible for administering people's medicines had their competency checked once a year to make sure their practice continued to be safe.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

At our last inspection, the provider had failed to keep accurate records of people's health care needs and treatment advice. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took enforcement action against the provider which has not yet been published. Full information about CQC's regulatory response is added to reports after any representations and appeals have been concluded.

At this inspection, improvements had been made to peoples' healthcare records. The provider was no longer in breach of this part of regulation 17.

● People had access to healthcare advice when they needed it. Staff contacted relevant professionals to either make appointments or ask them to visit people. These included, GP's, district nurses, opticians and chiropodists.
● Records were made when people had been seen by a healthcare professional and their advice was followed.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● No new people had moved into the service since the last inspection. The provider had undertaken initial assessments of people's needs before they moved in to the service when they had been in a position to take new admissions.
● The provider had reviewed people's needs since the last inspection and developed more detailed care plans as a result. These included, morning routine, evening routine, eating and drinking, mobility, oral hygiene and medication. Recognised tools had been used during assessments, such as to assess people's nutritional needs and skin integrity.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

● Not everyone could give us feedback about the service. Those who could said they were happy living there. One person said, "The girls are good, they try their best." Although there was a more relaxed atmosphere at this inspection, people continued to look bored and without purpose.

● Staff knew people well and spoke with fondness and compassion about people. One member of staff said, "I love working here. We are like one big extended family. I think people get really good care."

● However, the service had consistently been rated requires improvement or inadequate over six previous inspections. At this inspection the rating continued to be inadequate overall. This meant people were not consistently receiving good care.

● Staff had created a mural on the bedroom wall of one person, reminiscent of their cultural roots.

Supporting people to express their views and be involved in making decisions about their care

● People made some decisions and were involved in giving their views about some aspects of the service. For example, the food. However, there were many aspects where they were not included. For example, to follow their interests and to have some meaningful activity in their life.

● At the last inspection, people were not always encouraged to get up out of bed or were not always given the opportunity to get up when they wanted to. At this inspection, people were up and dressed at a time which suited them better. However, one person was encouraged to stay in bed one morning during this inspection, even though they told us they would have preferred to get up. The person was supported to get up and was sitting in the lounge later in the day.

Respecting and promoting people's privacy, dignity and independence

● The concerns found during this inspection as described through this report, and consistently through previous inspections, showed that people were not always respected.

● The provider did not always make sure people's needs and preferences were met. They had not made sure people's rights within the context of the Mental Capacity Act were closely protected.

● Staff supported people who liked to smoke to go outside to have a cigarette when they wished. Staff now stayed with people until they were safely sitting down, then left them until they were ready to come back inside, checking them from a distance to maintain their independence and privacy.

● Staff spoke to people with respect and maintained their privacy when supporting them with personal care tasks. For example, bedroom doors were closed when staff were assisting people and staff spoke quietly to people if they were asking if they wished to use the bathroom.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last inspection the provider had failed to maintain complete and accurate records. Concerns included the lack of regular reviews and recording of people's personal information such as their preferences. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took enforcement action against the provider which has not yet been published. Full information about CQC's regulatory response is added to reports after any representations and appeals have been concluded.

At this inspection we found enough improvement had not been made and the provider was still in breach of regulation 17.

● The provider had reviewed and updated people's care plans since the last inspection. These now provided a more detailed account of people's individual care needs and their preferences. However, some important information about people's care needs had been missed. One person was known to live with depression and anxiety. Although their care plan referred to how and when they became anxious, depression was not accounted for. The person was lying in bed most of the day, not wanting to get up. Their care plan advised staff to encourage them to get up. However, no reference was made to depression and how this may affect them, and the risk factors around this, such as lack of motivation and social isolation. The person was diagnosed with severe anaemia following a blood test. The information had not been used to inform care plans and how this may affect them. For example, tiredness and lack of motivation, to guide staff how to provide effective support to maintain their health and well-being.
● Different areas of people's care records did not always match; some parts had not been updated with important changes. This meant new or agency staff may not have the correct information to give the right support and encouragement to people. One person's care plan stated they had a good appetite and liked medium sized meals and referred to their enjoying second helpings of breakfast. Monthly reviews had taken place, confirming there was no change. However, another part of their care records, giving an overview of their care needs, recorded that the person now had a poor appetite and a monthly review reported the same thing.
● The GP had visited a person as there were concerns raised by staff. The GP diagnosed mild depression. This important information was not used to update care plans with guidance for staff how best to support the person, to prevent a deterioration in their wellbeing.

The failure to ensure accurate records were kept and updated is a continued breach of Regulation 17 of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's family and life history gave staff a good insight into people's lives before moving to the service. The routine people liked to follow when they got up in the morning or went to bed at night was recorded.
● Some people's needs had been effectively reviewed and recorded. Where their needs had changed, care plans had been updated. One person's mobility had declined, and they were advised to use an aid to support their movement from one area to another.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

At our last inspection the provider had failed to ensure that people's needs and preferences were met. Concerns included, lack of opportunity to take part in activities to support their interests and support to get up at the times they preferred. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took enforcement action against the provider which has not yet been published. Full information about CQC's regulatory response is added to reports after any representations and appeals have been concluded.

At this inspection we found the provider had not made enough improvement and they were still in breach of regulation 9.

● Observation charts were in place for people who chose or needed to stay in their rooms. The purpose of the chart was to avoid social isolation. It was clear from these that people were not engaged in any meaningful activity or regular conversation, and the provider had not identified this as a concern. The recordings staff made in one person's chart said for example, 'asleep', 'having a cup of tea', 'relaxing in chair', 'relaxing in bed'. Another person's chart recorded, 'enjoying roast dinner', 'having a coffee with 3 biscuits', 'repositioned and bed changed'.
● Most people were sitting in the lounge area through the day. Very few activities were available for people to take part in. On the first day of inspection, the television was on in the lounge with the sound turned off and sub titles turned on. At the same time, 1960's music was playing. This was a confusing situation which could prove disorientating for people living with dementia. When we raised this, we were told one person wanted the television on, but other people did not, so this was a compromise. Other ways to support person centred activity had not been considered.
● People were still not given opportunities to follow their interests and prevent boredom and social isolation. Although people's interests were recorded in their care plans, these were not used to encourage and support people to engage in activities they may enjoy. Activity records showed a lack of stimulation. In the month of January, the same activities were recorded for every person. Two dates related to watching a DVD and one to listening to a CD of music, neither were specific activities. The other two dates referred to external entertainers visiting.
● On the second day of inspection, a member of staff was engaging people in a game in the afternoon. Two external entertainers visited once a month each to support people with a musical interest and exercise sessions. Two events were held in July 2019 which people enjoyed. However, other initiatives to support people to gain enjoyment and prevent social isolation had not been considered.

The failure to ensure people's individual needs and preferences were met is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

At our last inspection the provider had failed to ensure complaints were investigated and responded to fully and to learn lessons to improve the service. This was a breach of regulation 16 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took enforcement action against the provider which has not yet been published. Full information about CQC's regulatory response is added to reports after any representations and appeals have been concluded.

● At this inspection, no formal complaints had been received, so although the provider was no longer in breach of regulation, we could not check if they were able to sustain improvement. One 'grumble' had been received from a relative and this had been dealt with at the time the concern was raised.
● The provider had a complaints procedure which gave the relevant information about who to make a complaint to and where to go outside of the organisation if they were not happy with the response to their complaint.

End of life care and support
● Staff understood people's needs and were able to describe how they provided end of life care to people. Staff were passionate about providing good care at this time, with concerns for people's loved ones at the same time.
● End of life care plans gave only basic information. Many people and their relatives had not wanted to discuss the subject. A record had not been kept of what encouragement had been given to discuss their preferences and to give direction about what they would like and what they would not like to happen. This is an area for improvement.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

At our last two inspections we identified an area that needed further improvement as the information provided was not in accessible formats. At this inspection, the provider had started to make improvements, and some accessible formats of information were now available, although this work needed to continue.

● One person's first language was not English. Staff had used an online translation service to provide the menu in the person's first language. They checked with the person that the translation was correct. An easy read poster was available to inform people about a chiropody service.
● Pictorial menus were also now available, with photographs of the meals offered to support people to make choices.
● The provider said they were planning to continue to provide more easy read and pictorial formats of information such as the complaints procedure.

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 inadequate. At this inspection this key question has remained the same. 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; Continuous learning and improving care

At our last inspection the provider had failed to ensure a robust approach to improving the quality and safety of the service. This was a continuing breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took enforcement action against the provider which has not yet been published. Full information about CQC's regulatory response is added to reports after any representations and appeals have been concluded.

At this inspection, enough improvement had not been made and the provider was still in breach of regulation 17.

● The provider had a monitoring system in place to check quality and safety, however, this was not affective. Not enough improvements had been made to identify the continued concerns and to show good quality and safety could be made and sustained. They did not have a plan in place to action the improvements needed following the last and previous inspections. This meant, although improvements had been made in a few areas following the last inspection, many areas had not improved, and this had been the case over many inspections. The lack of planning had impacted on the provider's response to serious fire safety concerns which had been slow, leaving people in a potentially unsafe environment without risks being assessed and managed.
● We found the lack of planning around consistent and effective cleaning had a detrimental effect on the service. The last three infection control monthly audits recorded that cleaning schedules were not completed, as a permanent cleaner was not in post. However, no record was made of what action was being taken to rectify this. Every cleaning schedule recorded that one person had 'refused' to have their room cleaned. The audits did not pick this up as a concern, so action could be taken. The provider told us staff cleaned the person's room when they were taking a bath. However, this was not evident from the records.
● A monthly managers audit checked that audits had been completed and what they had identified. However, clear action was not recorded from these audits to drive forward improvement. A 'manager's walk around' was completed some days. However, these were not effective, as concerns were not always noted, and action taken to rectify. For example, a daily walk around was completed the day before inspection. No concerns were highlighted. However, we found a number of concerns that needed to be actioned when we walked around during the first morning of inspection.
● People's care plans had improved and provided more detail about their needs. However, they were not

always accurate and were repetitive with the result of being very long. The manager's audit had identified that people's daily records did not reflect their care plans and the management team met with staff who said they did not have time to read the care plans. Staff were given a deadline of when to read all plans by, however, staff said they still did not have the time to meet the deadline. The provider had not considered any other solutions to ensure staff had the time to read people's care plans. The daily records staff completed were long and repetitive, recording the same detail each day. During the inspection staff spent a lot of their time completing daily records. The provider agreed staff were spending their time writing rather than with people but had not considered solutions to this.

● The provider, who was also the registered manager, and therefore legally responsible for the running of the service, was not on the staffing rota as part of the management team. They were listed as the domestic cleaner 8am to 4pm, Monday to Friday each week. They told us they carried out management tasks as well as cleaning. However, neither role was successfully completed as we found during the inspection. The provider had not kept their own training up to date. Apart from medicines awareness, they had not updated any mandatory training. Staff did not have a clear role model as roles were blurred and clear leadership was not evident.

● The management team, other than the provider/registered manager, consisted of a deputy manager and a care manager. Management tasks had been allocated to each member of the management team. This was not managed effectively, as information we requested could not always be provided by a member of the team. For example, on the first day of the inspection, we asked the care manager a question about the staff rota, as we were concerned a shift was not covered the next day. They told us they were not able to answer as they did not deal with the rota. They did not attempt to check this.

The failure to ensure a robust approach to improving the quality and safety of the service is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some audits were effectively monitoring people's safety. These included checking and analysing accidents and incidents, by identifying themes and taking action where needed. For example, if people had a number of falls, referring them to a healthcare professional.

● It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed a copy of their ratings in the main entrance to the service.

● Since the last inspection we recognised that the provider had failed to display their ratings on their website. This was a breach of regulation and we issued a fixed penalty notice. The provider accepted a fixed penalty and paid this in full.

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

● At our last inspection we found the provider needed to make improvements to make sure people received care that was individual and met their needs. As described through this report, we found the service was still not person centred. The opportunity to encourage and motivate people to enjoy their life by supporting their preferences and interests was still not taken by staff.

● Complete, accurate and up to date records to provide consistency and ensure people received the care they wanted and needed continued to be lacking. This meant the provider had consistently failed to provide a good service to people that met regulations.

● Staff were positive about the support they received from the provider and said they were happy in their

role. One staff member said, "I am very happy here, I am always pleased to come in to work. I love working with the residents here." Another said, "I think the whole staff team work together really well and I feel very well supported by the management team."
● At the last, and previous inspections, we found the provider had not listened to concerns from relatives. At this inspection, no complaints or concerns had been received so we could not check if the provider now had effective processes to make sure they listened to concerns to improve outcomes for people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Although the provider told us they held meetings with residents, they were not able to show us notes taken at the last meeting. Previous notes showed discussions about food only.
● Surveys had not been undertaken over the last two years to gain feedback and make improvements based on feedback received.
● Although relative's meetings had been planned, relatives had chosen not to attend so the provider was considering other ways to provide updates and gain formal feedback.
● Staff meetings were held regularly. Staff had the opportunity to raise concerns or ideas for improvement. Meetings were used as a coaching session if the provider had noticed areas that needed improvement in staff practice, such as daily record keeping.

Working in partnership with others
● The provider had not had the opportunity to attended local forums or national events to liaise with others and keep up to date with good practice.
● The provider had contacted other local providers and engaged with local authority commissioners and staff as well as health care professionals such as GP's and district nurses.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure people's individual needs and preferences were met Regulation 9 (1)

The enforcement action we took:

We cancelled the provider's registration with the Care Quality Commission. We worked with local authorities to make sure people were supported to find suitable alternative accommodation and care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure people's rights were upheld within the basic principles of the Mental Capacity Act 2005 Regulation 11(1)

The enforcement action we took:

We cancelled the provider's registration with the Care Quality Commission. We worked with local authorities to make sure people were supported to find suitable alternative accommodation and care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure risks were robustly identified and managed to prevent harm so people received safe care. Regulation 12(1)(2)

The enforcement action we took:

We cancelled the provider's registration with the Care Quality Commission. We worked with local authorities to make sure people were supported to find suitable alternative accommodation and care.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to ensure the premises is suitable for the purpose it is being used. Regulation 15(1)

The enforcement action we took:

We cancelled the provider's registration with the Care Quality Commission. We worked with local authorities to make sure people were supported to find suitable alternative accommodation and care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure accurate records were kept and a robust approach to improving the quality and safety of the service Regulation 17(1)

The enforcement action we took:

We cancelled the provider's registration with the Care Quality Commission. We worked with local authorities to make sure people were supported to find suitable alternative accommodation and care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff were deployed so people's care needs and preferences were met. The provider failed to ensure staff training was effective. Regulation 18(1)

The enforcement action we took:

We cancelled the provider's registration with the Care Quality Commission. We worked with local authorities to make sure people were supported to find suitable alternative accommodation and care.