Care Quality Commission

Phoenix Residential Care Homes Limited

# Phoenix Residential Care Home

## Inspection report

45 Maidstone Road
Chatham
Kent
ME4 6DP

Tel: 01634841002
Website: www.phoenixcarehome.org

Date of inspection visit:
03 November 2020
04 November 2020

Date of publication:
15 April 2021

Ratings

| Overall rating for this service | Inadequate |
|---|---|

| | |
|---|---|
| Is the service safe? | **Inadequate** |
| Is the service effective? | **Requires Improvement** |
| Is the service caring? | **Requires Improvement** |
| Is the service responsive? | **Requires Improvement** |
| 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 provides care and accommodation to younger adults, older adults and people living with dementia as well as other health conditions. The service can support up to 18 people.

People's experience of using this service and what we found
Although some improvements had been made since we last inspected the service, there continued to be serious shortfalls in the service provided to people.

Individual risks were not always assessed and managed to keep people safe. People could not be sure their prescribed medicines were always managed in a safe way. When people had accidents and incidents, action had been taken however, care plans and risk assessments had not always been reviewed and amended. Fire safety had improved, however their remained outstanding fire safety works.

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. We were not assured that the provider's infection prevention and control policy was up to date. 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.

Although people had an assessment of their care needs, this had not always been robust and had not been reviewed appropriately to ensure their safety and wellbeing.

People could not be assured there were enough staff on duty at night to make sure they could be evacuated safely if an emergency such as a fire took place. The provider was in the process of carrying out a review of staffing against peoples assessed needs. Since the last inspection, the cleaner had left. Some cleaning had been carried out by care staff. This meant that staff were taken away from care and support and activities to complete these tasks.

Although two people's care plans had improved, 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 opportunities 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. Since the last inspection, the provider had employed a consultant to help them improve the service. The consultant had been involved since 26 September 2020. Some improvements had been made since the last inspection, many improvements were still needed. Improvements that had been made needed to be embedded and then sustained. This was the ninth inspection where the provider had not achieved a rating of good and the fifth consecutive rating of inadequate.

People received healthcare from professionals when they needed it. People attended meetings to discuss the service and other important information. Those who did not attend were given opportunities individually to be involved after the meeting.

Staff wore appropriate personal protective equipment such as masks, gloves and aprons to keep themselves and people safe.

Staff knew people well. We observed caring, friendly interactions between staff and people. Staff recognised when people needed support or reassurance and provided this.

People were protected from the risk of abuse. Staff knew where they could go outside of the organisation to raise concerns if necessary.

Staff recruitment was now managed safely. Staff had received training to meet people's needs. Staff told us they felt able to ask for support and further training. Staff continued to receive regular individual support meetings and the provider held staff meetings to keep staff up to date.

People and their relatives had not made any complaints since the last inspection. People and some relatives had completed surveys of their care and experiences in September 2020. The provider had not yet had the opportunity to analyse the results and provide a response but knew that people had said were bored, and they had started to increase opportunities for activities.

People told the provider in their surveys; 'Quite happy with them, they do a good job'; 'I like the staff'; 'Nice staff'; 'Well supported here'; 'Everything fine' and 'Have a laugh with them [staff].'

Relatives commented in surveys; 'I have always found everyone at Phoenix to be friendly and kind, the staff have made me feel reassured about my mother's safety and wellbeing'; 'She seems happy and content more so than when she lived in her own home'; 'They [staff] are wonderful and caring, I know my mum is in great hands, I can approach them about anything' and 'Can always talk to management if I have any issues and always kept up to date with processes.'

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 16 September 2020). The provider completed an action plan after the last inspection to show what they would do and by when to improve.

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

Why we inspected
We undertook this inspection to gain an updated view of the care and support people received. This was a

planned inspection based on the previous rating. We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

The overall rating for the service has remained inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Phoenix Residential Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified continued breaches in relation to regulations 9, 11, 12, 15, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have also identified a new breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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

Follow up
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?**<br>The service was not safe.<br><br>Details are in our safe findings below. | **Inadequate** |
| **Is the service effective?**<br>The service was not always effective.<br><br>Details are in our effective findings below. | **Requires Improvement** |
| **Is the service caring?**<br>The service was not always caring.<br><br>Details are in our caring findings below. | **Requires Improvement** |
| **Is the service responsive?**<br>The service was not always responsive.<br><br>Details are in our responsive findings below. | **Requires Improvement** |
| **Is the service well-led?**<br>The service was not well-led.<br><br>Details are in our well-Led findings below. | **Inadequate** |

Care Quality Commission

# 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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by three inspectors. Two inspectors visited the service and a third inspector collated and reviewed information we asked the provider to send us by email during the inspection.

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. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with CQC. 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 announced. We gave the provider less than 24 hours' notice of the inspection. This was to check if any staff or people at the service were positive or had symptoms of COVID-19 and to discuss the arrangements for the inspection and personal protective equipment required.

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. Healthwatch told us they had not visited the service or received any comments or concerns since the last inspection. A local authority commissioner told us they had visited the service to carry out monitoring visits. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with five people who used the service about their experience of the care provided. We also spoke with two relatives. We spoke with seven members of staff including the provider, the deputy manager, team leader, support workers and cook. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with two community nurses who regularly visit the service.

We reviewed a range of records. This included eight people's care records and 13 people's medicines 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 policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, audits and staff allocation records.

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; Learning lessons when things go wrong

At our last inspection, the provider failed to ensure risks were robustly identified and managed to prevent harm and failed to consistently monitor incidents to learn lessons and mitigate individual risks. These included risks around ingestion of toiletries, choking and fire. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

- At the last inspection, people and staff were at risk of contracting COVID-19 as the provider had failed to isolate people returning from a hospital. At this inspection, people were being isolated on return from any hospital appointments. Before people were enabled to come into contact with other people in the service, they were tested for COVID-19 by the provider and on receipt of the negative result were enabled to join others in the communal areas of the service. We observed this happening in practice and the daily records evidenced this was common practice. There were no individual COVID-19 risk assessments for people to detail how COVID-19 may affect them and what action staff should take. The provider's overall COVID-19 risk assessment had not been amended and updated to detail that indoors visits had commenced and did not show what additional actions were taking place to keep people, staff and visitors safe.
- Since the last inspection the provider had updated two care files out of 13 and some risk assessments. Further work was planned on the remaining 11 care files which included risk assessments to make sure staff had up to date guidance and information to be able to support people safely. This meant that the majority of risk assessments remained unchanged and had not always been amended and updated when people's needs changed. One person had received treatment in hospital in August 2020. Their care plan and risk assessments had not been updated to reflect this, which meant there was no guidance for staff as to what they should do to support the person with their personal care whilst their wound was being treated and what they should do should they notice any changes to the wound or dressing.
- The risk assessments that had been amended showed that staff had clearer information about how to work with people safely. Some further improvements were required to make sure that risk assessments were person centred. Some risk assessments referred to males as 'her' and females as 'him'.
- At the last inspection risks had not been reassessed to protect people from the fire risks which Kent Fire and Rescue Service had identified in October 2019. At this inspection, fire doors around the service were working correctly and were no longer propped open with door wedges. However, there remained work outstanding to rectify fire risks such as work to remove ceiling tiles and compartmentation.
- Each person had a Personal Emergency Evacuation Plan (PEEP). The provider told us they were due to

start reviewing these, as they had not changed since we last inspected in August 2020. Therefore, the PEEP continued to contain basic information about the level of assistance people would need to reach a place of safety in the event of an emergency. PEEPs did not detail how many staff would be required to maintain people's safely once they had been evacuated. One person's PEEP recorded they could become anxious. There was no information about what staff should do to reassure the person and support their safe evacuation. Some people lived with dementia and would be at risk of harm if they were left unattended outside if they had been evacuated.
● One person had been prescribed an emollient cream which was highly flammable and came with a fire warning 'Clothing and bedding with this product dried on them can catch fire easily'. This had not been added to the person's PEEP and the provider had not included these risks in their risk assessments of the service.

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.

● Fire evacuation equipment was in place to aid the safe evacuation of people who were unable to safely use the stairs. Staff had now been trained about fire awareness. Since the last inspection there had been two fire drills. The drills included night staff. One member of staff told us, "I have done a fire drill, I have been shown how to use the evacuation sledge and I have practiced using it."
● At the last inspection people and staff were at higher risk of catching COVID-19 because staff were not wearing appropriate personal protective equipment (PPE). At this inspection, staff wore the PPE to keep people safe.
● At the last inspection a person living with dementia was at risk of ingesting liquids, such as toiletries, which were kept in their bedroom. A number of toiletries had been left within reach and could have caused significant harm if swallowed. At this inspection, the provider had installed a locked bathroom cabinet in the person's en-suite to ensure their toiletries were stored safely and securely.
● At the last inspection risk of choking had not been properly assessed or reduced. At this inspection, risk assessments were now in place, setting out clear guidance for staff to follow to minimise the risk of choking.
● The provider had revised their incident and accident reporting process. We reviewed completed incident and accident records. The records showed that a robust process was in place to identify action required at the time of the incident and afterwards. Staff received a debriefing following any incident. The provider had taken action as a result of incidents such as referring people who had fallen more than once to the falls team, to occupational therapists for equipment review and to speech and language therapists where people had choked or had swallowing difficulties.
● The provider had also started to use an accident/incident tracker to enable them to have oversight over the incidents and accidents occurring in the service and review any lessons learned.

Staffing and recruitment

At our last inspection the provider failed to ensure staff were deployed so people's care needs were met. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that the staffing numbers deployed during the day had reduced. There remained areas for improvement and the provider was still in breach of Regulation 18.

● At the last inspection, the staffing rota showed there were not enough staff on shift at night to be able to

safely evacuate people according to their assessed needs. The staffing levels at night had not yet been reviewed and remained the same.
● At the last inspection, assessments of staffing levels based on people's needs were conflicting and inconsistent. At this inspection, assessments of staffing levels based on people's needs were undertaken by the provider. The management team were in the process of carrying out a time and motion study to help them gain an updated view on the length of time it took staff to support people with their assessed needs. This study included a review of people's support needs at night as well as during the day.
● Since the last inspection a team leader and the cleaner had left. The team leader role had not yet been filled and so the provider was undertaking this role. This meant that they had been often working long hours, often working seven days a week without a break. We expressed concern that this was not sustainable for the provider's physical and mental health in the long term. The cleaner role had been filled and a start date arranged for 09 November 2020.
● The provider had not deployed an additional staff member to carry out daily cleaning tasks within the service. The provider told us staff picked up cleaning tasks when they could. Records showed that some cleaning had been carried out by care staff. This meant that staff were taken away from care and support and activities to complete these tasks. We observed the cook carrying out some cleaning tasks after they had completed their cooking tasks on both days of the inspection.

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

At our last inspection the provider failed to ensure staff were recruited safely in to the service by completing the appropriate checks. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements had been made at this inspection and the provider was no longer in breach of Regulation 19.

● At the last inspection the provider had not always followed safe recruitment procedures to ensure that staff employed to work with people were suitable for their roles. At this inspection, the provider had completed a thorough review of recruitment records and had identified a number of improvements for themselves, these were in the process of being rectified.
● At the last inspection, staff application forms had gaps in the employment history that had not been accounted for. At this inspection, the staff file we reviewed showed that a full employment history and reasons for gaps had been recorded. The provider had only employed one new member of staff since we last inspected the service.
● At the last inspection, staff had not always received Disclosure and Barring Service (DBS) clearance before they started work. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. At this inspection, a DBS check had been completed before the staff member started their employment.

Using medicines safely

At our last inspection the provider failed to take appropriate action to ensure 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.

At this inspection although some improvements had been made, further improvements were required, the provider was still in breach of Regulation 12.

● At the last inspection, the provider had not followed their medicines policy because medicines had been administered which had not been recorded on a medicines administration record (MAR). At this inspection, MAR charts were in place for each medicine a person was prescribed. A person told us, "Staff give us our medicines. They are always with you when you take them."
● At the last inspection, medicines were not always kept at the correct temperatures to maintain their efficiency. At this inspection medicines had been kept at the correct temperatures since 09 October 2020.
● At the last inspection, medicines had not always been disposed of safely. At this inspection, medicines were clearly recorded and disposed of in a safe manner. However, we checked the record book for medicines that may require additional storage to meet the British Standard level of security. We found that medicines for two people who no longer lived at the service were recorded as being still stored and in stock. These medicines were not in the medicine's cupboard. The provider had not maintained accurate medicines records for disposal for this type of medicine.
● At the last inspection, people on 'as and when required' (PRN) medicines did not have clear PRN protocols in place to detail to staff how to administer these safely. At this inspection, PRN protocols were in place for most PRN medicines. One person was missing a protocol for their laxative which was prescribed on an as and when required basis. This meant that staff (including those administering these medicines) may not have all the information they need about people's PRN medicines.
● At the last inspection, one person needed prescribed laxative medicine given regularly to maintain bowel function and to avoid constipation. Constipation would affect their health condition and cause them pain and discomfort. Their MAR showed they had been administered their laxative once in 19 days. There was no evidence that this was discussed with the person's GP or medical advice sought about how this would impact on their health. The risk to this person from constipation had not been reduced through administration of laxatives or seeking medical advice. At this inspection this person remained at the same level of risk. The MAR chart showed they had been administered their laxative on 16 out of 28 days and no medical advice had been sought.
● At this inspection we found medicines in stock did not always add up to what should have been in stock (according to the provider's records). For example, one person's laxative showed they had 14 sachets in stock however we found 15 sachets in stock. Another person's medicines did not add up to the amount of medicines in stock. We reported this to the provider, they carried out an investigation and reported to us that a medicines error had occurred on 04 November 2020. They sought advice from the pharmacist and appropriate action was taken to address this. However, had the medicines been counted by the staff member after they had administered the medicines the error would have been detected 11 hours before and reduced the risk of any adverse effect on the person.
● Medicines stock counts were completed monthly, which was not often enough to detect when people were running low on certain medicines. This increased the risk of medicines running out. One person had run out of one of their prescribed medicines on 31 October 2020 and had been without it for three days. The provider's systems had not detected that the person was running out of medicines prior to the 31 October 2020. The person had already missed two doses of the medicine before the provider took action to request an urgent prescription. The medicines quantity received at the start of the month did not tally with the medicines stock. The MAR showed 28 tablets of the medicine was received at the start of the month from the pharmacy, the person was prescribed one tablet each morning. The MAR chart shows that they ran out after 19 days, which the provider was unable to account for.

The failure to take appropriate actions to ensure medicines are managed in a safe way is a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Preventing and controlling infection

At our last inspection we recommended the provider consider current guidance on cleaning and infection control to update their practice accordingly.

● At our previous inspections, there had been an underlying odour present in two communal areas, even though the provider said they were cleaning the carpet regularly. At this inspection, the odour remained in the same two communal areas of the service.
● Since the last inspection the cleaner had left. Cleaning records showed that cleaning was not carried out in all areas on a daily basis. Staff confirmed that they did not complete this daily. Some areas were not in good repair and not always clean. Where areas of the service had been poorly maintained this would impact the ability to clean some surfaces and areas. Cleaning schedules had not always been completed to show daily cleaning had taken place in communal areas, so it was unclear how often cleaning was carried out. We checked a selection of records the provider gave us for from 19 October to 3 November 2020 and found that toilets had not been cleaned on four of 10 days, the sluice room had not been cleaned once. The records viewed did not specify which toilets in the communal areas had been cleaned on which days. It was unclear how often communal cleaning had been carried out.
● We observed that hand towel dispensers and hand wash as well as toilet roll were not always kept stocked up. The sink in the laundry room where staff would need to wash their hands after dealing with laundry did not have hand soap, sanitiser or hand towels on both days of the inspection.
● We were not assured that the provider's infection prevention and control policy was up to date.

The provider had failed to ensure the service was clean 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 were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.

Systems and processes to safeguard people from the risk of abuse
● The provider continued to report any concerns to the appropriate authorities.
● Staff had confidence in the management team and provider to appropriately deal with concerns. One staff member said, "I would report to [the provider] or [deputy manager], they would definitely deal with it and take action. [The provider] is very focused on residents and often says if the residents are happy then she is happy." Another staff member told us, "I am pretty sure that concerns would be acted on."
● Relatives told us their loved ones were safe. One relative said, "I feel that [my loved one] is safe here because she knows the staff and they know her."
● People told us, "I feel very safe. I have a bell at night and staff come if needed" and "I feel safe. They [staff] are here to help me when I need it."

Requires Improvement

# 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 now improved to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

At our last inspection the provider failed to ensure the premises was suitable for the purpose it was being used. This was a continued breach of regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection some improvements had been made, however, the provider remained in breach of Regulation 15.

● The environment remained almost unchanged from the last inspection. The service continued to need updating to provide a better maintained and better presented environment for people to live in. There remained plans in place to redecorate the service and fix areas that had been damaged since we last inspected following a water leak; and work to replace doors. A window at the front of the service on the first floor remained boarded up. A handyperson was on site carrying out essential works during the inspection. The provider told us the handyperson was going to be decorating one of the empty bedrooms on the first floor.
● At the last inspection we reported that people's rooms were bare and impersonal. At this inspection, the provider had started to work with some people's relatives to make people's rooms more personalised. Some people's rooms had not yet been started. Some bedding had been updated since the last inspection.
● During the inspection the handyperson fitted some of the dementia friendly signage the provider had previously purchased. This meant that some areas had dementia friendly signage in place. The provider told us they would be purchasing the rest of the signs to complete this.
● The smoking area for people was on a patio and had still not had a covered area installed to protect people from poor weather. The provider told us people were supported to go out to the back garden where a small covered area was available for people to use when the weather was poor. This was not an easy route for people because the ground was uneven and there were trip hazards. They would need to walk through the rain or wind to get to the covered area.

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

● At our last inspection maintenance and servicing checks on equipment such as bath chairs, hoists and

hospital style beds had not been completed. At this inspection additional maintenance and servicing checks had been completed. Some people had special beds with air flow mattresses to help keep their skin healthy. Three of these beds had been serviced since the last inspection. Other checks, such as emergency lighting, passenger lift, gas safety and electrics, had been completed. The provider had arranged to carry out a legionella annual test which was scheduled for 11 November 2020.
● At our last inspection a mattress partially blocked a walkway from the rear door to the patio. At this inspection, the pathway leading from the rear door to the patio area was now clear of obstacles.

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

At our last inspection the provider failed to ensure accurate records were kept to ensure people's care and support was safe and met their needs. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, the provider remained in breach of Regulation 17.

● At the last inspection, although people's care plans were detailed, they had not been reviewed and updated to reflect changes in need. At this inspection, the provider told us they were in the process of reviewing and improving people's care plans. Out of 13 care plans only two had been completed since the last inspection.
● Some people's needs and how they received support had changed, and care plans had not been updated to reflect the changes. One person used a hoist to help staff to support them to move around. They now had a different sling which meant they could safely sit on this in a chair through the day. We saw staff using the sling, and staff knew about the change, however, their care plan had not been updated with this information. This meant that new staff or agency staff may not have the up to date information to enable them to provide safe, effective care.
● Recognised tools continued to be used to assess people's nutritional needs and skin integrity. At the last inspection the tools had not always been used correctly which meant the risks may not be calculated correctly. At this inspection, the provider had introduced an additional tool to assess people's nutritional needs. The two tools sometimes gave conflicting results. One person was assessed as being at low risk of malnutrition using one tool, and high risk using the other tool. This conflicting information meant there was a risk people's needs would not be appropriately met. We raised this with the provider, and they confirmed after the inspection they had removed the additional tool and would use only one to prevent the risk of conflicting guidance for staff.

The failure to ensure accurate records are kept to ensure people's care and support is safe and meets their needs is a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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

At our last inspection the provider failed to ensure people's rights were upheld within the basic principles of the Mental Capacity Act 2005. This was a continued breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection the provider remained 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.

● No changes had been made to capacity and consent records. The provider told us they had not made any improvements to people's records except in relation to consenting to the flu vaccination.
● People had the opportunity to have a flu vaccination. The provider had completed a mental capacity assessment to check if people understood what this entailed to give their consent. Where people were deemed to lack the capacity to consent, the provider had recorded who had been involved in making the decision in people's best interest. However, what information they had taken into account and how they had come to the decision was not recorded.
● There continued to be limited evidence where people had been assessed as lacking capacity to make a particular decision, that the decision had been made in line with MCA 2005 Code of Practice and that the persons' rights had been properly considered.
● Care plans still did not provide clear guidance to staff to ensure the protection of people's rights where people had a DoLS authorisation. One person had a DoLS authorisation dated August 2020 with five conditions. These included, making sure mental capacity assessments should be decision specific and maintained in the care plan and following lifting of Covid-19 visiting restrictions, to contact an agency to seek a befriender. None of this information was considered in care planning. The person's care plan was one of two care plans reviewed and updated since the last inspection, yet this area was not included. This meant staff may not have the information they needed to understand people's legal status and make sure their rights were upheld. We referred this to the local authority after our inspection.

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 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We saw staff giving people choices throughout both days of the inspection.

Staff support: induction, training, skills and experience

At our last inspection the provider failed to ensure staff had the appropriate training to ensure people's needs were met. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection improvements had been made and the provider was no longer in breach of this regulation.

● At the last inspection, we reported staff had not received adequate fire training and, given there was an increased fire risk in the service, this posed a risk to people living at the service. Since the last inspection all staff had completed either fire marshal training or fire awareness. This provided staff with the knowledge to help keep people safe in the event of an emergency.

● At the last inspection, none of the staff with responsibility for cooking had completed the relevant training as specified by the Food Standards Agency. At this inspection, staff had all now completed training about food hygiene and some staff had learnt about nutrition and diet and allergens.
● Since the last inspection, additional training, such as dementia and the use of the malnutrition universal screening tool (MUST) had been completed. MUST helps to identify when people may be at risk of malnutrition or obese. Records showed staff were using MUST to monitor people's weight.
● The provider had started to update their own training. They still needed to update their safeguarding and equality and diversity knowledge to make sure they were able to provide the right support and advice to staff. This was an area for improvement.
● Since the last inspection no staff had received supervision with their line manager. However, six staff had received an appraisal of their performance. One staff member said, "I have just had an appraisal, everything was ok, I can ask for training and extra help." The provider had completed competency assessments of seven staff member's moving and handling practice and three staff members medicines practice. The provider had also developed an observation form to record direct observations of practice in other areas. One had been completed by the provider, it showed they had observed a staff member across the day gaining consent in relation to different decisions relating to care, medicines and moving and handling.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People had continued to be supported to access healthcare services to maintain their health. Staff had close contact with the GP and where people needed specialist care, referrals had been made. People had been referred to the falls team following more than two falls. A dietician had given advice and guidance when people had problems with their swallowing or were at risk of choking. District nurses visited regularly to dress wounds. We spoke to district nurses who confirmed this.
● When people had been unwell, or had a fall and staff were concerned they may have an injury, emergency services had been contacted quickly when required. People told us staff arranged for them to see health care professionals when they needed it. One person said, "I am really well looked after. Nurses come in regularly and [staff] call a doctor if I need one."

Supporting people to eat and drink enough to maintain a balanced diet
● People continued to be supported to maintain their nutrition and hydration needs. Staff kept good records of how much people had eaten and the snacks they had between meals. Staff now clearly encouraged people to drink plenty fluids and recorded the amounts people had drunk in the day. Fluid intake was added up and team leaders monitored the amounts at the end of the day to make sure people were drinking enough to maintain their health.
● Some people were advised to have a soft diet due to swallowing difficulties or were at risk of choking. Some people had diabetes so needed to be aware of the amount of sugar in their diet. Peoples' dietary needs and likes and dislikes were clearly recorded. The cook knew people well and could describe the consistency of people's foods, the size of plate they preferred and what foods people liked best.
● People continued to choose where they ate their meals. Although most people ate in the dining room, some people chose to eat in their room, or in the conservatory.
● People told us they enjoyed a choice of home-cooked meals. They said, "The food is perfect. The cook comes around to see what we would like. I like my vegetables raw, so the cook cuts me up some raw carrots with my lunch" and, "We have got a good cook. There is variety and we get a choice of what we want."

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 (February 2020) 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
● At the February 2020 inspection we reported that the service had consistently been rated requires improvement or inadequate. At this inspection the rating continued to be inadequate overall. This meant people were not consistently receiving good care.
● Not everyone could give us feedback about the service. Those who could said they were happy living there. People said, "[Staff] always look after us well", "[Staff] are very good and definitely kind" and, "I love it here. [Staff] are all nice and very kind."
● Staff knew people well and spoke with fondness and compassion about people. One person became anxious and confused at lunchtime on one of the days of the inspection. Staff provided gentle reassurance, showed kindness and gave the person a hug which is what they wanted. This helped the person relax and calm down and we saw them smiling afterwards.
● The atmosphere in the service was quiet and calm. People continued to look bored and without purpose. Seven people had fed back to the provider in their recent surveys that they felt bored. Three people had fed back to the provider in the survey that they felt lonely.
● One staff member shared how one person's television affected another person's ability to sleep at night because of noise disturbance. The television was loud as the person had a hearing impairment. The person had not been supported to obtain equipment such as earphones to enable them to watch and listen to their television programmes without disturbing others.

Supporting people to express their views and be involved in making decisions about their care
● At the last inspection of this key question in February 2020, 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. At this inspection, people who wanted to get up were supported to get up. However, people were not consistently given the choice of when to get up or go to bed. For example, one person told us, "[Staff] have just changed my time for getting up to 06:00. I used to get up at nine. They are just trying to get everyone up. I am happy getting up early." We spoke with the provider about this, they explained that the person had asked to get up earlier, so they had responded to their request. Another person commented, "I get up about 06:30. I don't really have a choice about it. I do as they [staff] say."
● People continued to make some decisions and were involved in giving their views about some aspects of the service; such as food. However, there were still areas where they were not included. For example, to follow their interests and to have some meaningful activity in their life. One person's care file which had been updated since we inspected in August 2020, showed that they had told staff that they never have drunk alcohol as they don't like it. However, staff had completed a consent form with the person which they had

signed to give their consent 'to drink alcohol providing it will not have an adverse effect on my prescribed medication.' This evidenced decisions about care were not always person centred.

- Staff described how they respected people's decisions. One staff member told us, "If [person] is not willing to engage with support or breakfast or chatting we try again in a little while and usually find [person] has changed [their] mind. We don't just leave it after the first try."
- People and their relatives were not actively involved in developing their care plan. One relative told us staff kept them up to date with changes or if their loved one was ill, but they were not involved in planning their care.

Respecting and promoting people's privacy, dignity and independence

- People were supported to maintain important relationships with people when they could. One relative told us, "I ring and chat to mum three times a week. She is finding not being able to see me indoors hard and doesn't always understand why." Restrictions caused by COVID-19 had made it more difficult for people and relatives. However, relatives had visited their loved ones in the garden when the weather was nicer. The provider was in the process of making arrangements to create a visiting booth to enable people and their relatives to meet in a safe manner indoors in the conservatory.
- 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 spoke with 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 discreetly with people when they asked if they needed any assistance to use the bathroom.
- We observed a number of times staff checking with people and helping to pull cardigans round people's shoulders when they were feeling cold. Staff assisted a person to actively walk around the service and keep them safe.
- People told us they tried to remain as independent as possible and that their privacy was respected. People said, "I look after myself as much as I can" and, "I like to watch films in my room. Staff pop up and check I am ok. They always knock first."

Requires Improvement

# Is the service responsive?

## Our findings

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

At the last inspection (February 2020) this key question was rated as inadequate. At this inspection this key question has improved to requires improvement. This meant people's needs were not always met.

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

At the inspection in February 2020, the provider had failed to maintain complete and accurate records. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, the provider remained in breach of regulation 17.

● The provider told us they were in the process of making changes to people's care plans, to provide clearer guidance for staff to support people with their care needs. Only two out of 13 care plans had been completed. The two completed care plans were more succinct and provided individual descriptions of people's care.
● Improvements to 11 people's care plans had not started. Some people's care needs had changed, and the changes had not been incorporated into the existing care plans. For example, the care plan of one person who was known to live with depression and anxiety had still not been reviewed to include how to best support them, since the inspection in February 2020.
● Another person's care plan continued to state they had a good appetite and liked medium sized meals, referring to their enjoying second helpings of breakfast. We found at the inspection in February 2020, when we last inspected this key question, the person had a poor appetite and concerns around their weight. Monthly reviews up to 5 July 2020 recorded they now had a poor appetite. No monthly reviews had taken place since then, and their care plan had still not been updated to reflect the change.
● The lack of up to date records meant people may not always get the person-centred care and support they needed from staff to maintain their health and well-being. Agency staff were being used to cover a staff vacancy. The provider was recruiting new staff, which meant it was crucial people's care records were maintained with up to date information.

The failure to maintain complete, accurate and updated records is a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff knew people well and could describe their care and how they liked to be supported.
● People told us they received the care they needed. Relatives said their loved ones' care needs were met. One relative told us the care and support their loved one received had improved in the last year.

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 the inspection in February 2020, 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 lack of stimulation.

At this inspection some improvement was now underway, although these had just started and still a work in progress. Further improvement was needed and the ability to sustain improvements needed to be evidenced, but the provider was no longer in breach of regulation 9.

● Staff were supporting people to take part in activities each day, which was an improvement. Although there were times people looked bored in the communal lounge, people were generally more engaged than they were at the last and previous inspections. People had been given the opportunity to be involved in some decisions, for example, if they wanted to listen to music, or if they wanted to watch TV.
● People who stayed in their rooms were now asked if they would like to join an activity. When they declined, staff spent one to one time with them in their room. Staff recorded when people had one to one time, however, they did not always record what they did during these sessions or what they talked about. This meant an opportunity was lost by the provider to learn more about people's interest and engagement in different activities and conversations.
● Although some people's interests were included in their care plan, this information had still not been used to support people to engage in activity they used to enjoy. For example, there was still no evidence that one person who liked to play board games had been given the opportunity to play their favourite games. Some people had interests that had not been identified in their care plan, for example reading books, which created more missed opportunities.
● The provider had appointed an activity lead from amongst the staff team. The staff member had started to work through activity books with three people and were looking to extend this to more people. People had enjoyed doing quizzes, putting names to faces and crosswords. The staff member had also recorded conversations they had with people to develop a memory box for each person, based on their loves, likes and interests. The staff member was excited about their new responsibility and told us they were looking forward to making changes to peoples' lives.
● People's views on keeping busy and remaining active differed. One person said, "[Staff] help keep us busy and give us entertainment. A gentleman comes in and sings sometimes". Others commented, "It is very boring. There is nothing to do. I watch the television in my room" and, "We play games, like bingo and guessing games. I would like to go out. Last year I went out three times. We did go out in the garden in the summer."

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.
● People's care plans and most information was not available in accessible formats such as easy read, pictorial and large print. The provider had included this in their improvement plan but had not progressed.
● Pictorial menus were available with photographs of the meals on the menu. A blackboard was now on display in the dining area with a written record of what was on the menu for the day. Although this was an improvement it would not suit everyone's needs as some people would not be able to understand it.
● The provider has told us at previous inspections they planned to develop an easy read complaints procedure. This was still not available, although included in the provider's improvement plan.

End of life care and support

● No people were receiving end of life care at the time of this inspection. People had an end of life care plan, however, these were still basic. No changes had been made since we last looked at this key question, in February 2020.
● People and their families had not been encouraged and supported to discuss their preferences further, beyond where they would like to be towards the end of their life, for example, at Phoenix Residential Care Home or hospital.
● Staff knew people and their relatives well and knew many of people's preferences. The provider told us relatives would be able to visit during the pandemic, within a controlled environment, if their loved ones were nearing the end of their life.

Improving care quality in response to complaints or concerns

● The last time we inspected this key question, in February 2020, the provider had not received any formal complaints. They had received one 'grumble' which had been dealt with appropriately.
● At this inspection, the provider told us again no formal complaints had been received. We had not received any complaints about the service at CQC and the relatives we spoke with said they had not made any complaints.
● People told us they would speak with the staff or the provider if they were not happy with something. They felt confident any concerns would be addressed. People said, "I would have a chat to the girls. I don't have to worry about too much" and "The staff are very friendly. I would talk to them if I was worried about anything."
● The provider's improvement plan included developing an effective complaints management system, however, this had not been prioritised for action yet.

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 failed to ensure a robust approach to improving the quality and safety of the service. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Since the last inspection the provider had instructed the help and support of a consultant to help them make improvements to the service. The consultant had been to the service on three days 26, 27 and 28 September 2020 and had written a report detailing the improvements required. This mirrored the findings of our last inspection. Since the report was written, the provider had submitted a weekly improvement plan to CQC and other key stakeholders. The consultant has provided remote assistance to the provider through telephone calls, emails and video calls.
● The provider's improvement plan showed that staff had been allocated lead roles in certain areas such as leading on nutrition and hydration, pressure area care, health and safety, infection control, medicines, dementia, dignity in care and activities. We spoke with staff who had been allocated lead roles, they told us that they had not undertaken any work around these lead roles yet, they did not fully understand what the purpose and function of these roles was.
● The provider appeared more confident and in control at this inspection, they had better oversight of the service because they were actively involved with providing care and support as well as other duties including cooking. The provider was honest and upfront about areas of improvement that had not yet been started, such as care plans, risk assessments, building improvements, audits and checks.
● At the last inspection, we continued to find that people were at risk of harm. This was because risks to them were not always recognised by the provider, or where risks were identified not enough was done to minimise them to keep people safe. Not enough improvements had been made to identify the continued concerns and to show good quality and safety could be made and sustained. At this inspection, although improvements had been made in a few areas, many areas had not improved. As some improvements had only just been made it was difficult to judge whether the provider could sustain and embed the improvements. Audits and checks of the service are essential to give the provider and management team an oversight as to what impact the improvements they have made on people's care and support and the safety

of the service. The provider told us they had planned to complete audits in the future with the support of the consultant they had employed.

- The provider had carried out very few audits since we last inspected in August 2020. Those that had been completed did not link to an action plan. For example, the infection control audit completed on 29 September 2020 included checking that moving and handling equipment was cleaned between uses. In the comments box the auditor noted; 'No evidence re stand-aid'. There was no evidence that action had been taken to address this shortfall. This infection control audit identified soap dispenser and hand sanitisers needed to be kept topped up. The providers improvement plan dated 30 October 2020 noted, 'On the 10th October an hourly toilet check was completed and placed in the communal toilet, this is undertaken by a member of staff to ensure that the area is clean and that there is sufficient toilet roll, hand wash and paper towels'. During the inspection, we found a number of toilets and sinks for handwashing without essential products.
- The registered manager's monthly audit dated 03 September 2020 had identified some areas and actions had not been taken. For example, the audit had identified that the shower heads had not been cleaned, which meant that legionella risks had not been mitigated and cleaning records were not being completed because a cleaner was not in post. There was no associated action plan for this audit to show what action was to be taken, who would complete the action and by when.
- At the last inspection, we found the lack of planning around consistent and effective cleaning had a detrimental effect on the service. At this inspection, cleaning schedules had been partially completed, however communal areas were regularly missed off the schedules, so there was no record of them being cleaned. During the COVID-19 pandemic, attention to hygiene and infection control is especially important.
- At the last inspection, medicines audits were not robust. The medicines audits had failed to identify concerns we found during the inspection which included missing essential documentation and temperature of storage areas. The audit had not identified that one person had frequently declined their medicine, which they were prescribed to manage a health condition. This meant an opportunity to discuss this with the person's GP had been missed. At this inspection, we found once again that the same person frequently declined their medicine to manage their medical condition and this had not been addressed. A medicines spot check of another person's medicines on 05 October 2020 had failed to check the emollient the person was prescribed so had missed the fire risks to the person.
- At the last inspection, the provider had not put adequate plans in place to manage people's safety in the event of a fire because essential works had not been completed. At this inspection, some of the outstanding essential fire improvements had been made such as repairing emergency lighting and fixing the fire doors. Some work remained. We observed that vacuum cleaner was still stored in one fire escape despite us raising this with the provider at the last inspection.
- After the last inspection, the provider informed us that flushing of taps in empty rooms in the service would be conducted weekly from 31 August 2020 to meet the Health and Safety Executive's (HSE) guidance in managing legionella in hot and cold-water systems. At this inspection we found that the empty room flushing had only happened twice since we last inspected (31 August 2020 and 06 October 2020). This demonstrated that potential risks continued not to be well-managed.
- At the last inspection, we found that care plans were not always accurate and large sections of information were repeated which made them difficult to read. There was a lack of oversight in relation to care plans when people's health had changed or declined or where accidents and incidents had occurred. This meant the opportunity to amend and embed changes in to people's care plans and risk assessments had been missed. At this inspection, two out of 13 care plans had been amended within the 12-week period to make them easier to read and understand. No work had been taken to review and amend the other 11 despite people having changes to their health and care needs in that time period. This created an opportunity for staff (including new and agency staff) to follow the wrong guidance about people's care needs.

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

● Some audits were effectively monitoring people's safety. For example, audits which checked and analysed accidents and incidents, by identifying themes and taking action where needed. These showed that where people had a number of falls, they had been referred to a relevant healthcare professionals.
● At the last inspection, staffing audits were not robust. At this inspection the staffing and recruitment audit had been completed, it was comprehensive, and actions had been identified. The provider was working through the actions. However, some improvement was still required as the action plan for this audit did not include information about who would complete the improvements and by when.
● A health and safety audit had been completed in late October 2020 by an external party. A detailed action plan had been provided. This included the areas of non-conformance, corrective action needed and noted who would complete the action and by when. The provider had not yet begun to address the actions.
● At our last inspection water temperatures had not been checked consistently. Since the last inspection water temperatures checks had been completed each month to make sure water was not too hot for people living at the service.
● 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 entrance hall to the service to ensure people could see the report.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff confirmed the provider and management team continued to support them well, were approachable and always available to listen to concerns.
● Most staff said the staff team worked well together. Staff explained they received good clear communication and handovers between their shifts so they knew important information and any changes in people's health. Comments made by staff in their surveys included, 'If I need help the manager or team leader will always help me' and 'my manager is very approachable.'
● We observed people interacting with the provider and management team and knew them well. People were seen entering the office and approaching the provider throughout the inspection.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had not always notified us of incidents relating to the service. These notifications tell us about any important events that had happened in the service. The provider had failed to report a serious injury which had occurred on 13 October 2020 and a DoLS authorisation which had been authorised by the local authority on 19 August 2020.

The failure to notify CQC in a timely manner about incidents that had occurred is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

● The provider had notified relatives of incidents relating to their loved ones. A relative told us they felt well informed and said, "The staff keep me updated."

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

● Staff held regular meetings with people to get their views and provide updates. The main topics people discussed were food and menus, and activities. People spoke about what they would like for Christmas dinner and staff spoke about plans to help their relatives to visit in the winter during the time of Covid-19 visiting restrictions.
● At the last inspection, the provider told us they had not undertaken any survey to gain feedback. They said they intended to survey people and relatives in September 2020. The survey had recently been undertaken. Twelve people had completed and returned surveys as well as seven staff and seven relatives. The provider told us they had not yet had the opportunity to analyse the results and provide a response. They said initial review showed a number of people (six) said they were bored, and they had started to increase opportunities for activities. Three people said they felt lonely. A relative had commented in their survey, 'I would like residents go have more mental stimulation, quizzes, word games, number games, activities. I would like my mother to be encouraged to have some exercise/movement most days, especially to help keep her leg muscles strong. Without this I worry she may gradually become less mobile. [regular exercise would probably be good for general wellbeing.]'This is an area the provider needs to respond to quickly to provide more opportunities for meaningful occupation to prevent the risk of social isolation.
● The provider held a staff meeting at the end of September 2020, after the last inspection. Staff were updated on the last CQC inspection report. The provider highlighted the many areas where improvements were needed, reminding staff of their responsibilities and enlisted their support in driving forward improvements. The introduction of new systems and processes was discussed with staff, along with the reasons for the changes.

Working in partnership with others
● The provider had not yet had the opportunity to attend through video link local forums or national events to liaise with others and keep up to date with good practice.
● The provider had joined local infection prevention and control provider and manager networks, which they had found useful.
● The provider continued to maintain contact with local authority commissioners and staff as well as health care professionals such as GP's, district nurses and the falls team.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>The provider had failed to notify CQC in a timely manner about incidents that had occurred. Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. |

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 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider had failed to ensure people's rights were upheld within the basic principles of the Mental Capacity Act 2005.<br>Regulation 11 (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 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider has failed to take appropriate actions to ensure medicines are managed in a safe way. The provider has failed to robustly assess and manage risks relating to the health, safety and welfare of people.<br>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<br><br>The provider had failed to ensure the service was clean and properly maintained and failed to ensure the premises is suitable for the purpose it is being used.<br>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 |
| --- | --- |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to ensure accurate records are kept to ensure people's care and support is safe and meets their needs and failed to ensure a robust approach to improving the quality and safety of the service.<br>Regulation 17 (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 18 HSCA RA Regulations 2014 Staffing<br><br>The provider had failed to ensure staff were deployed so people's care needs were met.<br>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.