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:
27 June 2019
28 June 2019

Date of publication:
06 April 2021

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 accommodating up to 18 older people in one adapted building over two floors. There were 16 people living at the service at the time of our inspection. People had varying care needs, including, living with dementia, recovering from a stroke and diabetes. Some people could walk around independently, and other people needed the assistance of staff or staff and equipment to help them to move around.

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 who used the service was not good.

People were not protected from harm by robust safety measures to reduce risks. There were concerns around, people's individual care; risks around the premises such as fire safety measures, unlocked doors to hazardous areas and laundry management; how people received their prescribed medicines and the monitoring of accident and incidents to learn lessons and prevent reoccurrence.

The numbers of staff on shift did not ensure people received the individual care needed to support their health and well-being. Recruitment of new staff followed safe practice.

Staff did not always receive training to keep their skills up to date. New staff did not complete essential training in a timely manner to make sure they had the knowledge to provide good support and keep people safe. Staff had one to one meetings with a manager and said they felt supported to do their job.

The evidence was not available to show how some people who were at risk of malnutrition were fully supported with their food and fluid needs. People were supported to access healthcare when they needed it. However, the advice given was not always used to update their care plans and therefore the advice was not always followed.

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.

The premises needed updating and although this had started in some areas of the service, it was slow and incomplete. Some people's bedroom carpets needed replacing as they were worn and torn.

People's care plans had improved in part but did not always provide up to date information as they had not been reviewed and people's needs had changed. People's daily records showed people did not receive the care they needed, for instance, some people were left in bed late which meant they missed essential care. People were not provided with the motivation or opportunity to follow their interests or offered meaningful

occupation to prevent social isolation and maintain their well-being.

Staff knew people well and spoke about them in a caring way. We saw some caring interactions. People were supported to share their end of life wishes and these were documented. One relative told us their loved one had received good care at the end of their life.

People and their relatives were not encouraged to share their concerns and complaints in the knowledge they would be listened to. The provider did not take the opportunity to learn from complaints to make improvements.

The management and oversight of the service was not robust enough to identify areas of concern and put actions in place to continuously improve quality and safety. Improvements had not been made since the last inspection or previous inspections. This was the sixth inspection where the provider had not achieved a rating of good.

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 (inspected 27 November 2018 and published on 13 March 2019) and there were multiple breaches of regulation. We took enforcement action against the provider. We served two warning notices telling the provider they must make improvements to the quality and safety of care. We told them they must become compliant with Regulation 12 by 11 March 2019 and with Regulation 17 by 25 March 2019. The provider submitted a plan of action to show what they would do, and by when, to improve. At this inspection we found the provider had failed to make enough improvements and they were still in breach of regulations.

Why we inspected
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 breaches at this inspection in relation to, risks to peoples safety and the safe management of their medicines; staff training and the numbers of staff on shift; people's rights and how they consent to their care; the support to maintain peoples nutritional needs; how complaints and concerns were dealt with; accurate record keeping and the lack of oversight of the quality of care by the provider.

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? 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**

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.

Inspection team
The inspection was carried out by two inspectors on the first day and one inspector on the second day of 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 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 who 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. Through this report the registered manager/provider is referred to as the provider.

Notice of inspection
This inspection was unannounced on the first day. We announced when we would return for the second day.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to

complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service and one relative about their experience of the care provided. We received feedback from another relative by email after the inspection. We spoke with seven members of staff including the provider, the operations manager, senior care workers, care workers and kitchen staff. 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 reviewed a range of records. This included six people's care records and many medication records. We looked at three staff files 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 sent by email. We contacted the Kent Fire Rescue Service to ask them to visit the service to check fire safety in the service was compliant with regulations. We spoke to local authority commissioners who had visited the service. They shared their concerns with us as they found similar issues we found during the inspection.

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 now remained the same and continues to be rated inadequate. 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. 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 and served a warning notice telling the provider they must be compliant with regulation 12 by 11 March 2019.

At this inspection, we found the provider had not complied with the warning notice and continued to be in breach of regulation as they had not made sufficient improvements to make sure people received safe care.

- Individual risk assessments were in place and had improved since the last inspection. However, they did not provide the guidance needed for staff to keep people safe.
- Guidance for staff when using the hoist to support people to move from one area to another did not include some important safe practice, which meant people were at risk of harm. On day one of the inspection, staff used the hoist to assist one person to move from their bed to a chair in the lounge area. The sling attached to the hoist was left underneath the person when staff left them sitting in their chair following the transfer. This meant the person was not able to sit safely as they were sliding down the chair. We raised this with the deputy manager who told us this was not normal practice. However, on day two of the inspection, two staff who had been in post three to four months were struggling to remove the sling from under the person. Staff eventually asked the trainee manager to assist them. The trainee manager showed staff how to remove the sling safely. This suggested it was not normal practice to remove the sling once the person was seated as staff did not have the skills to carry this out.
- Another person's risk assessment documented they would not ask for drinks, so they could become dehydrated. Staff were not given guidance about how often they must offer the person a drink and how much the person should be drinking through the day to reduce the risk of dehydration. The person was often in bed until late morning and sometimes until late in the afternoon. Staff had not consistently recorded if they had offered drinks while the person was in bed. Daily records did not evidence they had enough to drink throughout the day. This meant the person's health and well-being were compromised as they were at risk of becoming dehydrated.
- Management plans to prevent people at risk of acquiring pressure sores did not provide staff with the guidance needed to prevent harm. One person was unable to move their legs. Their care plan noted they were able to move around in bed independently, but staff should check their pressure areas regularly as they had a history of their skin becoming red and sore. A position change chart was not in place to make sure staff helped the person to change position safely without damaging their skin and to check their skin remained healthy and intact. On 25 June 2019 their daily records recorded a red area of skin, but no further

record was made to evidence further checking. The person told us their pressure areas did get sore.
● Personal emergency evacuation plans (PEEP's) are a guide for staff and emergency services to provide information about people's mobility needs to enable their support to evacuate the building in the event of a fire or other emergency. PEEP's were basic with limited information. One person needed a hoist to assist them out of bed. Their PEEP stated they would be unable to evacuate the building as they used a wheelchair but did not describe what staff needed to do to support their safe evacuation.
● Fire drills were carried out annually to check staff were able to evacuate people safely. The last two drills were dated 26 September 2017 and 26 November 2018. Both drills documented staff needed more practice. However, the opportunity for staff to practice, to make sure people could be evacuated safely and in a timely manner, had not been taken and annual fire drills continued. Many new staff had started in post since the last fire drill, so their knowledge had not been tested. This placed people at risk of not being evacuated safely and quickly should a fire break out.
● Health and safety concerns were present around the premises. Some doors to hazardous areas were not locked when they should have been, as staff were not present in the area. This placed people at risk of being harmed. A sluice room (where used bed pans, commodes and urine bottles were cleaned by a specialist machine) was unlocked.
● An empty bedroom was in the process of being painted. The room was full of painting equipment and tins of paint. Although there was a lock on the door, the key was in the door so easy to open. These areas posed a concern to people's safety as potential risks and hazards were open to them if they ventured through any of the doors unaccompanied.

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

Learning lessons when things go wrong
● Accidents and incidents had been recorded by staff on the appropriate forms. The provider checked the forms to make sure they were completed correctly. However, they did not monitor incidents to identify themes and put action in place to learn lessons and prevent further occurrences.
● One person had two falls resulting in hospital visits. The provider checked the forms and recorded the person was being visited by a physiotherapist. However, care plans and risk assessments had not been updated to provide staff with guidance to prevent further falls or learn lessons from the circumstances of the recent falls.

The failure to ensure lessons were learnt from incidents so people received care that continued to be safe is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

At this inspection, we found the provider had made some improvements; staff administered people's medicines in a safer way, guidance was available for staff about 'as and when necessary' medicines; when we did a random count of medicines they all tallied. The provider had introduced a new monitoring system for staff to check the amounts of medicines in stock every day. People did not always receive their prescribed medicines on time which put their health and well-being at risk.

- On both days of inspection, the morning medicines round, to give people their first medicines of the day, was carried out late. The staff member responsible for administering medicines told us this was the case each day, as they had other tasks to attend to. Arrangements were not in place to make sure another member of staff could take over the administration of people's medicines, or relieve the staff member with their other tasks, so they could continue. Although the morning medicines round had started before 9.30am on the second day of inspection, the staff member administering medicines was not able to continue due to other priorities. Another member of staff did not take over administering medicines. The medicines round resumed at 11.15am. This meant that most people did not receive their medicines as prescribed which could impact the rest of the day's medicines. For instance, people who took medicines regularly three or four times a day would not have been able to take the next dose at the correct time, or people would not be able to take the prescribed number of painkillers.
- A document in one person's care plan entitled, 'What is important to me', stated that among other things, pain relief was important to them. The person was often in bed very late in the day and was not offered their pain relief as they needed to be taken after food. The person was not offered breakfast or lunch until they got up so did not have their pain relief until then. This meant the person was potentially left in pain while in bed and when they were being supported to move. A physiotherapist had advised the person on 13 June 2019 that they take their painkillers regularly, morning and evening. Their care plans had not been updated with this information. Both days of inspection the person was not given their first dose of pain relief until about 12pm. They were prescribed pain medicine up to four times a day. As they did not always receive their first dose until late, this meant they could not have pain relief four times a day if they needed it.

The failure to ensure medicines were managed safely and administered as prescribed is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The ordering, storage and returns of medicines were managed in a safe way. Medicines administration records were legible, so they were easy to monitor and check for mistakes. There were no gaps in medicines records. The temperature of the medicines room was checked each day. Some medicines need to be stored within a safe temperature range to maintain their effectiveness.

Preventing and controlling infection

At our last inspection, the provider had failed to investigate and eradicate a strong smell of urine that was evident in the service. This had been an ongoing concern from the previous inspection when a recommendation was made. This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found the provider continued to be in breach of regulation as improvements had not been made and the strong smell of urine continued in the premises.

- A full time cleaner was not employed. A member of staff worked as a cleaner 30 hours a week. However, some of their time, usually one day a week, was spent as a trainee manager, which meant they did not spend 30 hours a week cleaning. The provider said they and other staff also helped with cleaning. The service was not clean. No cleaning was being carried out during the inspection. Some carpets needed vacuuming and this was not done.
- There was a very strong odour of urine in the service. This had not improved since the last inspection. The smell did not reduce through the day and was worse in some areas, including some bedrooms, and the lounge in the afternoon.
- A particularly strong odour was coming from one bedroom, even though the door was closed, meaning

the smell permeated into the surrounding hallways. The provider and operations manager said they had not been able to do anything to improve the smell, even though we had raised this at the last inspection. We asked to enter the room where the smell was strongest and found a large pool of fluid on the floor of the en-suite bathroom. The smell was overpowering. This had been undetected by staff, although they were aware this could be an issue and was clearly an ongoing problem.
● The provider asked a maintenance person to check the bathroom to check other sources of the odour. They found a broken toilet, and this was in the process of being repaired during the inspection. However, the sources of the odour found during the inspection had gone undetected since the last inspection and people had been left to contend with it.
● Dirty linen was not disposed of quickly and appropriately following best practice guidance. A blue bag full of laundry smelling of urine was found on the floor of a communal bathroom. The bag was not closed which meant people could walk in and look in the bag and touch the contents.
● The laundry room was not a clean area and was not organised to control the risk of infection. Designated areas for dirty/hazardous linen, standard dirty linen and laundry that had been cleaned was not evident. The room was in the basement area and smelled of damp. Damp areas were evident on one wall. There was no evidence this had been identified as a maintenance concern.
● Boxes for people's clean laundry were standing on the unclean floor of the laundry room. The operations manager told us they were planning on putting shelves up to stack the laundry boxes on. However, in the meantime an infection control hazard was present.
● Waste bins, including hazardous waste bins, were a flip top design, rather than foot pedal controlled lids, in the laundry room and some other areas in the service. This was an infection hazard as people and staff would need to touch the lids with their hands to use them to dispose of waste. We spoke to the infection control lead, who said they had identified this as a concern to the provider, however, the bins had not been changed.

The failure to ensure the service was visibly clean, free from offensive odours and properly maintained is a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● The provider had previously used a dependency tool, to help them to assess the numbers of staff needed, based on people's assessed needs. This had not been used since October 2018. The provider told us the tool had not met the needs of the service and they had not found another more suitable dependency tool to use.

● Three staff were on duty each shift during the daytime. One of these was a team leader who was responsible for the running of the shift. The team leader administered people's medicines and dealt with any concerns such as contacting healthcare professionals for advice or GP's to visit people. This meant they were not always available to provide people's care and the two remaining staff had this role. Some people needed two staff to support them to get out of bed in the morning, to go to the bathroom and to go to bed at night.
● Although staff told us they thought there were enough staff on duty to meet people's needs, some of the concerns we found during the inspection showed the amounts of staff available impacted on the care provided. Many people remained in bed until late morning or sometimes into the afternoon. We were told this was people's choice, however this was not the feedback we received from people and their relatives. One person told us they would have preferred to get up earlier, "I have asked to get up, but they are busy, it's okay I know that they are really busy, and I am okay, but I did want to get up." People were having breakfast as late as 11.05 and 11.45 as they got up late. Medicines were given to people late morning/lunchtime instead of early morning as prescribed, as the team leader was busy with other priorities.

● The domestic cleaner did not work full days and was busy training as a manager some days of the week. Staff did not have time to keep the service clean when the domestic cleaner was unavailable.
● An activities coordinator was not employed, and staff did not have time to provide meaningful activities for people to keep them occupied. One staff member told us about a person who walked around from one room to another, and said, "If there is nothing else going on we will spend time with (the person) and chat with them."
● A local authority commissioner told us they had concerns there were not enough staff to meet people's needs when they visited soon after the inspection.

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

● 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.

Systems and processes to safeguard people from the risk of abuse
● Two new staff, one who had been in post one month and another two months, had not received safeguarding vulnerable adults training. Another staff member had undertaken the training with a previous employer, in January 2018, however, the provider had not checked their knowledge by providing their own training.
● The staff we spoke with were able to describe what constitutes abuse and which organisations to contact if they had concerns. Staff told us they were sure the provider would deal with any concerns straight away. However, there were areas of concern found during the inspection that staff had not recognised as areas that should be questioned around people's care. For example, people being left in bed late and missing meals and essential care or not being given their medicines as prescribed. This is an area that needs improvement.

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 requires improvement. At this inspection this key question has now deteriorated to a rating of inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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.

At this inspection, we found although staff had been given the opportunity to update their training and skills in specific areas, there continued to be gaps in the training provided.

● At the last inspection we reported that staff had not received training to make sure they had the skills to provide positive support to people whose behaviour they found challenging. The provider told us in their action plan this training would be provided by the end of April 2019. Staff had still not received this training. The provider told us this had now been booked.
● Staff had not received diabetes training at the last inspection. The provider told us in their action plan that seven staff had been in the process of completing this training at the time of the last inspection and this was now completed. We found only five out of 14 staff had completed diabetes awareness training and one of these had been in a previous employment. Although some staff had left the employment of the service, the provider had not made sure more staff had completed the training. Staff provided care and support to people with diabetes.
● New staff had not completed all the essential training to make sure they had the basic skills and knowledge to provide people with the appropriate care. One staff member started in their role on 9 April 2019. They had not completed any training at Phoenix Residential Care Home, although they had brought certificates from previous employment. However, these did not include moving and handling or Mental Capacity Act training. Another member of staff who started on 20 May 2019 had not yet completed safeguarding vulnerable adults training, Mental Capacity Act, fire safety or food hygiene training.
● Staff had not received practical based moving and handling training. One of the newer members of staff said, "The team leader showed me how to hoist and they checked that I was competent before I was allowed to do this by myself, including making sure I wasn't getting any bad habits." However, the team leader was not a trained moving and handling trainer so was not qualified to provide the practical training.

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

● Staff told us they received a good induction and were given the time to gain confidence. One member of

staff said, "They went through all of what you can and can't do and the do's and don'ts. I read the care plans and I shadowed quite a bit because I had not done this work before, it's not for a set time, it's until you know what you are doing."
● Staff told us they received regular one to one supervision with a senior member of staff to support their personal development. Staff said they found this a supportive process. One member of staff commented, "I do get supervision and they listen to things we have to say. It's really good to work here."

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

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.

At this inspection we found the provider continued to be in breach of regulation as improvements had not been made. Changed treatment advice had not prompted a review of care plans and risk assessments.

● Although people had been referred to the appropriate healthcare professionals for advice and treatment when needed, evidence that their advice had been followed was not always available.
● One person attended an appointment with a physiotherapist, accompanied by their loved one, on 3 June 2019. The person's relative informed staff what had been advised and this had been documented by staff; '(The person) to have further sessions and they must not (underlined) walk unaided by staff to the toilet and must use a wheelchair to go to the dining room, otherwise they will fall (underlined), until the next appointment'. Care plans and risk assessments had not been updated to make sure staff knew to follow this advice. Daily records did not refer to the advice being followed. The physiotherapist returned on 13 June 2019. The multi-disciplinary record stated the person walked to the dining room with a walking aid. The record was not clear if any other advice was given around mobilisation or exercises. Care plans were not updated. On 15 June the person had a fall and paramedics attended. The person was taken to hospital' but no injuries were found.

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 had access to healthcare advice. Health care professionals had been contacted when necessary. People had regularly seen opticians and chiropodists, as well as GP's and district nurses. People's care plans included guidance for staff regarding their oral health care and whether they had their own teeth or used dentures.

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.

At this inspection we found the provider continued to be in breach of regulation as improvements had not been made.

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.

● Capacity assessments were not completed consistently, where it was thought people may not have the capacity to make particular decisions. Staff had completed an assessment regarding one person's capacity to make the decision for staff to administer their medicines. The assessment found the person could not retain the information needed and did not have capacity to make the decision. No other capacity assessments had been carried out regarding other decisions of equal complexity, such as consenting to their care and treatment.
● One person had a DoLS in place which meant they had been independently assessed as lacking the capacity to make informed decisions about their care and treatment. No records were kept, to show how decisions had been made in their best interests. None of the person's care plans referred to the DoLS authorisation to make sure staff were aware of the restriction and had the guidance they needed to uphold the person's rights.
● Some people's relatives had signed consent forms with no explanation why the person had not signed. One person's son had signed various consent forms. The person's care plan stated they had the capacity to make decisions. The consent forms did not state if the person preferred their loved one to sign on their behalf, or if the forms had been discussed with the person.
● Another person's relative had signed their consent forms. The forms stated the person lacked the capacity to sign, however, elsewhere in the care plan it was recorded the person did have capacity but let their relative sign on their behalf.
● The guidance was not available for staff to make sure people's rights were respected and upheld.

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 could describe how they supported some people to make day to day choices. One staff member told us, "In the morning I got out the shirt and (the person) shakes their head, so I offer another choice and keep going until (the person) selects one."

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

At our last inspection, the provider had failed to ensure accurate records were maintained around people's nutrition and hydration needs. At the last inspection, this was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the provider had not always sufficiently addressed the risks to people's health which constituted a breach of a different regulation.

● One person's nutrition care plan documented the dietician had recommended a fortified diet as they had a small appetite and were at risk of malnutrition. For instance, they recommended the person should have full fat milk, and homemade milk shakes. Staff had also been advised by the dietician to offer finger foods and snacks throughout the day to supplement their meals. The person's food chart showed they were not offered snacks through the day and there was no evidence from their daily records that their diet included finger foods or homemade milkshakes.
● The cook told us no people were on a fortified diet, although they knew the person was underweight and had hot chocolate with cream on top.
● The daily records showed the person often did not get out of bed until late morning and sometimes into the afternoon. This meant they missed breakfast more often than they had it and, according to their records, they sometimes also missed lunch as they were not offered lunch until they were out of bed.
● On 26 June 2019, staff recorded in the person's daily food record; no breakfast, 'fast asleep 8am until 11.20am', when they had two spoons of cereal and then ate quarter of their lunchtime meal. On 25 June, staff recorded in their daily food record; no breakfast, 'fast asleep 8am until 2pm', then half a jacket potato for lunch. On 23 June, staff recorded in the daily food record; no breakfast, 'fast asleep 8am until 4pm, half a roast dinner at 4pm then, 'declined scone at 5.30pm and a biscuit at 8pm.
● On the second day of inspection, after we raised our concerns, the person was up when we arrived at 9am and the provider told us they had been happy to get up and have breakfast.
● The person's weight chart showed they had lost 5.7kgs (12.54 lbs) in the 10 weeks between 23 April and 1 July 2019. They had seen a dietician, but their advice was not updated into the care plan and not followed. A comprehensive food and fluid chart was not in place, to keep track of exactly what the person ate and drank throughout the day. This meant the risk of malnourishment was not closely managed and monitored.

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

● People had two choices at mealtimes and could ask for something different if they wished. Although people were asked what they wanted to order for lunch and tea, a menu was not on display. There were mixed views about the food provided. The comments we received about food included, "I did not enjoy my lunch because I thought it was gammon not salmon"; "I am happy (with the food)" and "The food is nice, I enjoy it."
● People sitting in the lounge were regularly offered drinks through the day and one person said, "Staff are very good at keeping my juice topped up."

Adapting service, design, decoration to meet people's needs
● Maintenance issues were evident around the service. Some of these concerns had been logged in the maintenance book. However, many were still ongoing. For instance, on 24 June 2019 a staff member had reported, 'bench with iron sides unstable in small garden'. We checked and found the bench remained in place and was still unsafe. A sign was not in place to indicate the bench must not be used. The area was used as a smoking area for people who chose to smoke cigarettes. A member of staff supported one person to go outside to smoke. The member of staff was helping the person to sit on the bench until we intervened. The staff member was not aware the bench needed repair.
● A covered area was not available for people who chose to smoke. This placed them at potential risk of ill health during inclement weather such as heat, rain or wind.
● Many areas of the service needed updating. Many carpets were worn or torn, and some furniture needed renewing. The carpet in one person's bedroom was torn and a trip hazard as the edges of the tear were curled upwards and were frayed. The provider told us the carpet tiles stacked in the sluice had been

purchased to lay in the room. However, there was no planned date for this and the state of the carpet posed a risk.
● Although signs identified toilets and bathrooms as well as people's bedrooms, the layout, décor and flooring were not dementia friendly. However, we did not see people struggling to find where they needed to go. For example, toilet seats were white. Best practice guidance for supporting people living with dementia advise contrasting seat covers so people can distinguish the toilet seat area.
● The provider told us at the last inspection decorating was ongoing but had been put on hold for the winter months. At this inspection, although some bedrooms had been decorated, the communal areas were still in need of updating. Decorating tape was evident along the edges of the stair and hallway carpet, the tape was worn and torn in places as it had been down for some time. When we asked about this, we were told it was left until decorating could resume again. The tape was a potential risk, some people may feel the need to remove it or check what it was. As the tape was at floor level this could create a fall hazard if people bent to check what it was.

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

● Some people's rooms had been decorated to their own personal style and choice. One person had chosen wallpaper and had personal items of furniture in their room.

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. However, at the last inspection we found the provider carried out an assessment with people before they moved in to the service. The assessment covered the person's needs in relation to their, personal care; eating and drinking; mobility; cognition and medical history, identifying what support was needed and this was used to develop the care plan. Information from other sources such as assessments by health or social care professionals were also used.

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 and continues to be rated requires improvement. 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
● The atmosphere was not happy and relaxed. People did not easily join in conversation. There was an air of boredom and lack of enjoyment from people.
● Staff knew people's needs and could describe their care. However, people were at risk of social isolation as there was not a culture of encouragement and motivation.
● Staff were obviously fond of people and enjoyed telling us about them, speaking in a caring way. We saw some caring interactions between staff and people during the inspection.
● The people who were able to speak to us did not give negative views of the service but were not animated when speaking about the staff or when asked if they were happy. The comments we received included, "The staff are nice enough to me, I am okay here"; "I like her, the carer, she was nice to me. Yes, the rest are okay too"; "No I'm not bored, I like being on my own really" and, "It's okay here, I'm okay. I get on well enough."

Supporting people to express their views and be involved in making decisions about their care
● Time had been spent by staff to involve people more in care planning. More information was available about people's past history and what was important to them.
● However, people were not always supported to be more involved in their care as they were not always asked when they wished to get up out of bed. Some things that were important to people, such as controlling their pain, was not always considered by staff.

Respecting and promoting people's privacy, dignity and independence
● The concerns found during the inspection, as highlighted through this report, showed that people were not always respected. Staff did not keep accurate records of people's care to make sure their needs were consistently met by good communication.
● The provider did not make sure people's needs were met and healthcare advice was included in people's care plans to make sure the advice was followed.
● A strong odour continued to be present within the service despite this being raised at the last inspection and the provider saying they would take action.
● People were not always encouraged and supported appropriately to get up out of bed to remain active and to maintain their independence.

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. 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. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the provider continued to be in breach of regulation as improvements had not been made.

- Some improvements had been made to care plans, providing more individual information about people, with some detail to show how people liked their care to be provided. However, these continued to need more personal information. Life histories, although in place, were restricted with the information gathered. They followed a question and answer format which often only contained one, or two, word answers, so the information about some people's lives was scanty.
- One person's family history was recorded by a staff member who had written the person had shared their memories of World War Two D-day and being in the forces. However, these memories were not recorded, or how they felt, so other staff could use this information to engage in conversation with the person.
- Not all records within people's care plans were dated which meant it was difficult to be sure each record contained up to date information. For example, a one sheet 'mini care plan' was in use so staff could see people's support needs at a glance. These were not always dated.
- Some care plans were reviewed each month and others were not. One person's care plan had not been reviewed since December 2018. The provider told us they were in the process of changing all care plans and this person's care plan was one of the few not yet completed. However, changes to their care needs were evident but had not been included in the care plan.
- The person was at risk of pressure sores. Their pressure area care plan had not been reviewed since October 2018. However, it was evident through health care professional visits their skin had broken down and they were receiving treatment. A record of one visit by a health care professional, in May 2019, showed they asked staff to change the person's bath day to when they were visiting, ready for their treatment. There was no record of this within the care plan or evidence that their request had been carried out.
- Another person's care plan had not been reviewed between February and June 2019. However, health care professionals had visited and given advice regarding treatment in this time and the concerns or advice were not updated into their care plans or risk assessments. For instance, a healthcare professional had visited to check a wound to the person's leg in January 2019 and had advised, although healed, their skin

was fragile and when washing and drying, staff should take extra care with their legs. Another visit in March 2019 gave similar advice about another part of the body where concerns were raised. Neither professional advice had been included in their care plan guidance.

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.

● Some people were not provided with the care and support to meet their needs. People were not always supported to get up at the times they preferred or to meet their individual needs. One person remained in bed late most days. There was evidence their relatives had raised concerns about this as they felt it affected their well-being. The provider and operations manager told us the family had raised concerns but said it was the person's choice to stay in bed. The person was supported to get out of bed at 11.45am on the first day of inspection.
● We checked the person's care plans and daily records. Care plans did not record the person preferred to stay in bed, and recorded they had capacity to make less complex decisions as long as they were given the information in a simple way. One part of their care plan said it was important to them to have their pain relief, so they did not experience pain. Elsewhere in their care records it was recorded that a dietician had advised on their dietary needs which included snacks through the day as they were at risk of malnutrition.
● The person's daily records did not evidence that staff had encouraged the person to rise earlier in the day to make sure their individual needs were met, or to provide for their needs when they made an informed choice to remain in bed. For example, on 30 June 2019 staff had recorded; '6am (person) in bed at start of shift', '10am (person) remains in bed sleeping on checks', '12pm check done - fast asleep', '3pm did personal care and had a drink'. There was no evidence the person had their personal care needs attended to, or had any food, drink or medicines all day until 3pm. Records did not evidence what encouragement was given to the person to rise earlier to support their continued health and well-being. A mental capacity assessment had not been undertaken to make sure the person could understand and retain the information needed to make an informed choice about this particular decision.
● Another person sometimes chose to stay in bed later in the morning. Their care plan guided staff to check before breakfast what time the person wanted to get up and explain they may need to wait if staff were busy with other people. The care plan advised staff to go back at regular intervals to reassure they hadn't forgotten them. However, staff told us, they sometimes asked the person in the morning if they wanted to get up but sometimes not until the afternoon, as they often changed their mind. During the inspection, the person was still in bed late morning and told us they had wanted to get up earlier. They were not always given the opportunity to make their own choices about when to get up and to change their mind if they wished.
● The person's daily records did not give assurance that the person was asked if they wished to get up and the agreements reached each day. On 26 June 2019 the daily records showed the person had stayed in their bed all day. No record was made by staff if they had chosen this. On 24 June, no information was given if the person was asked by staff if they wished to get up, and no record at all was made in their daily record between 1pm and 2.20am. Similar records were evident through the daily records, for instance, on 1 and 2 June 2019, the person was in their room in bed all day with no written evidence they had been asked if they wished to get up.
● The records did not provide assurance people's needs and individual preferences were met to support and maintain their health and well-being and meet their preferences.

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

● Care plans contained more information about some people's individual needs, giving better guidance to staff. One person who was from an ethnic minority community was supported to visit a specific supermarket to buy foods and treats from their country of origin once a month. Staff told us they had supported the person to celebrate a time of cultural significance by taking them on a trip to London to enjoy the celebrations.
● Staff could tell us about people religious needs and how they supported them if they had specified needs. For example, supporting people to attend church services when they were able.
● People, and their relatives where appropriate, had signed a record to confirm they had been involved in developing their care plan.

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.

At this inspection we found the provider continued to be in breach of regulation as improvements had not been made. Concerns were still not listened to and lessons were not learnt.

● The provider told us they had received no complaints, or even concerns or 'grumbles' since the last inspection. However, we were aware that some family members had raised concerns. The provider and operations manager told us about one of these during the inspection. Although a relative had been clearly upset about an issue raised, the provider told us this was not recorded as the relative had apologised. However, the concern itself was relevant. The opportunity to listen to and learn from concerns and to make improvements continued to be missed.
● People were not encouraged to raise concerns or worries before they became a bigger issue that impacted on their well-being. Some people told us they were not confident about raising a complaint. One person commented, "I don't like to complain, because then they make a sad face and have a sad face all day."

The failure to ensure people's complaints and concerns were listened to in order to learn lessons and make improvements is a continued breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● 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.

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 we identified an area that needed further improvement. People were often not meaningfully engaged to meet their social and emotional needs. At this inspection we found no improvements had been made and the provider was now in breach of regulation.

● Care plans to make sure people's assessed needs and preferences for meaningful occupation each day were not in place to provide guidance for staff to enable them to support people's motivation and well-being.

- An activities coordinator was not in post to plan activities to provide people with meaningful activity and provide an outlet for their interests. A coordinated approach to providing activities had not been improved on since the last inspection. The provider told us the cook continued to provide some activities for two hours, three afternoons a week.
- External entertainers visited the service two or three times in the month and the provider occasionally held a special event. In the month before the inspection, three days of external activities or special events had been held; on 30 May 2019, visits by a singalong entertainer and animals to observe, on 6 June, an afternoon tea event and on 20 June, animals to observe again. As these were held in the communal areas, only people who were able, or chose, to come out of their rooms could access them. This meant people were not provided with suitable social stimulation.
- There was little in the way of activities for people during the inspection. Throughout the morning, the television was on in the lounge area, some of the time with the sound turned off and separate music playing. People were either falling asleep or were sitting with nothing to do to provide motivation and stimulation. Staff did not sit and chat with people. A game of bingo was organised by the cook with people sitting in the lounge in the afternoon on the first day of inspection. Many people were not engaging and joining in. Nine people were sitting in the lounge but only four people joined in. Those who did join in the game were not given encouragement and the opportunity was not taken to engage people in conversation.
- One person's care plan recorded they liked to play various board and card games. There was no evidence in daily records the person had been given the opportunity to follow these interests.
- People who were too frail to leave their room, or who chose to stay in their room through the day, were not offered anything in the way of activity or support to follow an interest. The comments staff made to evidence meaningful activity throughout ten days of one person's daily records were, on 20 June 2019, 'animal lady here and stroked the animals'; on 19 June, 'joined in bingo' and 10 June, 'had hair cut'. Apart from these three records every other day staff had recorded 'relaxing in lounge, 'out for a smoke' or 'bed for a rest'. Most people's daily records did not include any reference to meaningful activities. This meant people were at risk of social isolation and their well-being compromised.
- One staff member described the activities they were aware of as being on offer for people, "There is an exercise lady that comes in – I think once a month. The cook does bingo once or twice a week, when she finishes dinner she does this – once a week maybe."

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

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 inspection we identified an area that needed further improvement as the information provided was not in accessible formats. At this inspection this area had not improved, and accessible formats of information were not available.

- Consideration had not been given to how people understood the information they were given and to provide material in more accessible formats. For example, the menu was not displayed for people to see, we had to ask to see it. The menu was not available in picture format to help people who found reading words a problem, to make a decision about their meal choices. This is an area that continued to need further improvement.

End of life care and support
● One relative contacted us following the inspection to share their positive views of the way their loved one had been cared for, including at the end of their life. They said their loved one had been, 'Loved and cared for by the staff' and at the end of their life they were, 'Treated with respect and love'.
● People's final instructions in the event of their death were recorded in an end of life care plan. Some of these were quite basic with limited information as not everyone wished to discuss the subject.
● Other people and their relatives had been happy to share their wishes. For instance, if people wanted to be buried or cremated and who would take care of the arrangements, for example, family members. People were asked if they had any spiritual or religious considerations they wished to be taken account of. One person specified their favourite flowers they would like to have.

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 accurate record keeping and ensuring 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 and served a warning notice telling the provider they must be compliant with regulation 17 by 25 March 2019.

At this inspection, we found auditing processes were in place. However, the provider had not met the warning notice and continued to be in breach of regulation as these were not far reaching enough to show the provider had an oversight of the quality and safety of the service they provided. The provider had not identified the many concerns found during the inspection.

● A 'Manager's audit' had been completed each month since January 2019. The operations manager carried out the audit. The audit covered many areas of the service, including; people's care, activities, maintenance, safeguarding, training and supervision. Some areas were found that needed to improve and an action plan had been completed. The manager's audits had not identified many of the areas of concern we found during the inspection.
● Where some areas had been identified, these had not been addressed. For example, the strong smell of urine in the service had been recorded on the action plan in March and April 2019. The action planned recorded a new cleaner was being employed. The audits following this, in May and June 2019 did not mention the smell of urine even though it was still evident during the inspection as reported. This meant the opportunity to improve the environment for people had not been taken.
● The manager's audit showed the issue of having no activities organiser in post was identified each month. However, no action was planned to establish an interim arrangement until recruitment had taken place. This meant, although the need for improvement had been identified, action had not been taken to improve opportunities for meaningful occupation that met people's needs and preferences and to prevent social isolation.
● Regular audits of the management of people's medicines had been carried out since January 2019 by the trainee manager. Although areas for improvement had been found and action plans in place to make sure the necessary action was taken to improve, the provider had not considered the areas of concern found during the inspection. People were not receiving their medicines at the times prescribed or advised by a

healthcare professional. Some people were at risk of being in pain as the timeliness of giving people their medicines had not been prioritised.
● A health and safety audit had been carried out by a member of staff each month since January 2019. An action plan was in place, identifying some areas that continued to need improvement each month, for example, deep cleaning carpets. The auditor had confirmed each month that no unpleasant odours were found. However, the manager's audit in January and February 2019 had noted the smell and it was clear during this inspection that this had been present since the last inspection.
● The provider did not check the accuracy and quality of care plans. They said they had been re-writing all care plans so did not think this was needed. However, some care plans had been rewritten in February 2019 and changes in some people's care were evident since then. The provider had missed the opportunity to check that staff were following the care plan and recording changes where needed.
● The trainee manager checked daily records each day. They initialled them to evidence this. However, no comments were made about the accuracy of records or if the care described matched people's care plans and care needs. The trainee manager told us they checked they were completed correctly. If they found concerns, they spoke to the staff on duty but did not record this. The trainee manager confirmed they had not identified the concerns we found with daily recording. We found significant concerns with some people's daily records, as reported, and the care they were receiving based on these. This had not been identified as a concern through the monitoring in place and had therefore gone undetected by the provider.
● Although monitoring processes had been introduced, they were not robust and had not identified the significant concerns we found to be continuing within the service. The provider did not have an oversight of the service even though they were based in the service most days. The provider did not undertake any auditing to assure themselves the process in place was effective in checking the quality and safety of the service.

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.

● Registered managers are required to notify the Care Quality Commission (CQC) about events and incidents such as abuse, serious injuries and deaths. The provider had understood their role and responsibilities, had notified CQC about all important events that had occurred and had met their regulatory requirements.
● 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 and on their website.

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
● Staff were positive about the support they received from the management team and felt they could raise any concerns or ideas for improvement with the provider. They told us the provider had supported them with their own personal issues. One member of staff said, "I feel supported here. They support me to understand things, they explain stuff to me."
● However, we found the service was not person centred as described through the report. Staff misunderstood what choice meant and how to encourage and motivate people to enjoy their life by supporting their preferences and interests.
● The management team did not understand the need for complete, accurate and up to date records to provide consistency, to ensure people received the care they wanted and were assessed as needing. This

meant they had consistently failed to provide a good service that met regulations.
● When people or relatives raised concerns, these were not always listened to and the provider failed to take action that could have improved outcomes for people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider had held meetings with people to gain their feedback. Although meetings had been held in January, May and June 2019, none of the meetings had been displayed for people to see or copies given to people for them to read. The provider told us they had not yet been typed up. This meant people were not given the opportunity to check the notes and remind themselves what was discussed and if any actions had been agreed.
● Staff meetings were held, although the notes had not been typed up and were still amongst the provider's work. This meant staff who had not been able to attend had not had the opportunity to keep up to date with what had been discussed and if any action had been agreed they needed to be aware of. The provider had missed the opportunity to improve communication and make sure discussions of good practice or improvements needed was not missed by any team members.

Working in partnership with others
● The provider told us they used to go to local providers forums but haven't recently as they had prioritised trying to make improvements in the service.
● 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.
● At the last inspection, relationships had deteriorated between the service and some healthcare professionals. The local authority had been involved in trying to resolve the issues. The provider told us communication had much improved. We had not had concerns raised by the healthcare professionals since the last inspection.

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 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)(2)

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 were suitable for the purpose they were being used; was visibly clean; free from offensive odours and properly maintained. Regulation 15 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to ensure people's complaints and concerns were listened to in order to learn lessons and make improvements. Regulation 16 (1)(2)

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 and staff received the training to meet people's needs.

Regulation 18 (1)(2)

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)(2)(3)

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; the robust management of infection control; lessons were learnt from incidents and medicines were managed safely and administered as prescribed. 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 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure accurate records were kept and updated and a robust approach to accurate record keeping to ensure the quality and safety of the service. 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.