Serene Residential Care Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Serene Residential Care Limited is a residential care home providing accommodation for people who required nursing or residential care for up to 35 people aged 65 and over. At the time of the inspection the service was supporting 21 people.

People's experience of using this service and what we found
Risks were not safely managed in relation to people's care. Where risks were identified, such as for infection prevention, pressure care, choking, moving and handling, there were inadequate processes in place to ensure people's safety.

Records of people's care and support were not adequately kept. Care plans did not sufficiently reflect people's needs and were not up to date. Daily records were not kept accurately.

Fire safety procedures were not adequate and staff did not all know how to support people in the event of a fire.

Safe recruitment procedures were not followed. DBS checks and references were not always sought before staff began work, and agency staff were deployed without identity checks verified. There were concerns with staffing rotas, which showed some staff worked excessive hours without rest days. There were weaknesses in staff training to ensure they had the skills to support people safely.

Feedback received from people and relatives was largely positive, and they said they felt safe and supported. However, this inspection identified a continued lack of person-centred care and there were no meaningful activities for people to engage in. Staff worked with patience and care, although they had little opportunity to engage with people, other than when supporting them with care tasks.

The registered manager was enthusiastic and expressed the will to make changes when these were identified. However, there was insufficient evidence of driving improvement or overview of the risks in the service, both to individual people and within the environment. There was poor quality auditing in place; matters identified at the last inspection and raised by the local authority partners had not been addressed and there was a deterioration in the standard of care.

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 Requires Improvement (published 20 July 2021).
The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
We received concerns about lack of staffing, people's dietary needs not being met, lack of recording and poor management of the service. As a result we undertook a focused inspection to review the key questions of Safe and Well-led only.

We reviewed the information we held about the service. No areas of concerns were found in the other key questions. We therefore did not inspect them. Ratings from the previous comprehensive inspection of those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.

We have found evidence the provider needs to make improvements. Please see the Safe and Well-led sections of this report.

You can see what action we have asked the provider to take at the end of this full report.

Following this inspection the provider has told us some improvements have been made to ensure care plans are accurate and people are safely supported

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 breaches in relation to person-centred care, safe care and treatment, staffing and recruitment, and safe management of the home.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

If the provider has not made enough improvement in this timeframe and if 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 means 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 of 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Serene Residential Care Limited

Detailed findings

Background to this 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
This inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Serene Residential Care Limited is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the 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.

We reviewed information we had received about the service. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection
We spoke with six people who lived in the home and four relatives. We also spoke with the nominated individual, the registered manager, the cook, and five care staff.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at the recruitment of seven staff members. We looked at records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance 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 Requires improvement. At this inspection this key question has now deteriorated to 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. This was a 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

• Risks were not robustly assessed or measures put in place to reduce the risk of harm to people.
• Staff did not know who was at high risk of choking, or what to do to support them. Where people needed modified texture diets to prevent the risk of choking, these were not consistently given and there was conflicting information in care records. One person who should have had a very soft food consistency was given biscuits and sandwiches. There was no choking risk assessment in the person's care plan.
• Thickening powder prescribed for people who were at risk of choking on drinks was unsafely stored in the bread bin and we saw people accessed the kitchenette area at times. Staff gave information about which people needed thickener added to their drinks, but this was different information to a list on the cupboard door.
• Staff did not know which people were at risk of pressure ulcers or who should be seated on pressure relieving cushions. Staff did not all know who had diabetes or the signs of concern. Staff did not all know which people had a catheter or how to provide appropriate care.
• Unsafe moving and handling techniques were used to support people to transfer between wheelchairs and armchairs. Staff had recently completed training in moving and handling, although they did not demonstrate safe ways of working.
• Personal emergency evacuation plans (PEEPs) were not readily accessible in the event of a fire. Staff did not all know what to do if they heard the fire alarm.

Using medicines safely
At our last inspection, the provider had failed to robustly record medicines. This was a 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.

• Fridge and medicine room temperatures had not been recorded in September 2021 and there were gaps in

recording of this in August 2021.
• There was poor recording of one person's medicine patch and another person's prescribed dietary supplement drinks were signed for but not given.
• The management of people's medication was not robust. One person who had difficulty swallowing was given medicine in tablet form.

We found no evidence that people had been harmed, however systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Preventing and controlling infection

At our last inspection, the provider had failed to ensure safe infection prevention and control measures. This was a 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

• We were not assured that good infection control practice was being followed.
• None of the inspection team were asked for any evidence of COVID-19 testing.
• One person's bedding was stained and a dirty towel was being used to dry people's dishes and cups. This had been raised during a visit by the local authority the previous week and no action had been taken.
• We saw two members of staff touching their face masks and wearing their face masks under their nose and chin. Staff came to/from work wearing their uniforms.
• There was no ventilation in the communal areas.

We found no evidence that people had been harmed, however systems were either not in place or robust enough to demonstrate infection prevention and control measures were effectively managed. This placed people at risk of harm. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• Relatives said they had to follow the visitors' protocol which included testing for COVID-19.
• There had been increased cleaning hours in response to concerns received.

Staffing and recruitment

At our last inspection the provider had failed to ensure robust recruitment of staff. This was a breach of regulation 19 (Recruitment) 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 19.

• We found concerns with recruitment checks. DBS checks and references were not always obtained before staff began work. This was a concern at the last inspection but had not been addressed.
• Agency staff's identity or training status had not always been verified prior to them working in the service.

We found no evidence that people had been harmed, however systems were either not in place or robust

enough to demonstrate safe recruitment was in place. This placed people at risk of harm. This was a continued breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People and relatives told us there were enough staff. Some staff said there were not enough staff to support people's needs. Staff rotas showed there were sometimes only two staff working at night, when the provider's dependency assessment required three. There was not always a senior carer deployed at night, which meant there were no staff on duty who could support people with medicine if needed. Staff rotas also showed staff worked excessive number of shifts, sometimes totalling an 84 hour working week without rest days.
• Interactions between staff and people were gentle, patient, kind and respectful. However, staff did not have time to spend in conversation or meaningful activity with people because they were busy completing care tasks. There were no activities staff. Some people said they felt bored and we saw most people spend their day seated around the room or wandering without purpose.
• At lunchtime, one member of staff supported people in the downstairs dining room, but there were no other staff available to assist people to go back upstairs when they wanted to.
• Systems and processes were not robust enough to ensure there were enough staff who were suitably skilled to care for people safely. For example, no practical training had been completed in first aid. There was no evidence of staff completing any training in relation to catheter care.
• Staff told us they were required to complete e-learning, but some staff said they had not yet done this. Training records showed some staff had taken multiple attempts to pass e-learning topics, but with no follow up evident for learning/knowledge checks. Some staff completed multiple e-learning courses in a day.

We found no evidence that people had been harmed, however systems were either not in place or robust enough to demonstrate safe staffing was in place. This placed people at risk of harm. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• Staff had completed medicines training and their competency had been assessed.

Learning lessons when things go wrong
• The last inspection identified several areas to improve and breaches in regulations. The issues found at this inspection mirror the findings of the last inspection as well as the findings from visiting professionals and there has been insufficient action taken to address matters of concern.

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 Requires improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high quality care.

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 robust systems of governance. This was a 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

• This inspection highlighted continued concerns from the last inspection and a deterioration in standards. The management team did not demonstrate the knowledge and expertise to address the regulatory breaches since the last inspection and ensure the home was running safely.
• There was no overview of the key risks in the service. The management team did not know the risks to people without referring to individual care records.
• There had been some changes to the management team as the deputy manager had recently left the service. The registered manager had competing tasks which were placing a considerable burden on their time and they demonstrated limited ability to prioritise improvements in a systematic, methodical way.
• There was no system and process in place to ensure care was being delivered in line with people's needs. Care plans were not up to date or accurate and reviews were not systematic or timely. Where there were known risks, such as choking, there was no management oversight of practice. Although accidents and incidents were recorded, there was no analysis of the information to identify lessons learned and prevent reoccurrence.
• Where audits were completed and actions were identified, there was no evidence of when these had been completed. For example, the August 2021 medication audit highlighted gaps in recording and the action was 'continue to monitor' but there was no evidence of monitoring and this was still an issue at this inspection.
• The provider had produced an action plan in response to local authority contacts team carried out a series of monitoring visits in August 2021. These identified a variety of concerns including medicines, the environment, staff training, cleanliness and incomplete care documentation. The action plan showed the identified concerns were being or had been addressed. However, at the time of the inspection continued concerns in these areas were identified, with no evidence of any robust monitoring.

We found no evidence that people had been harmed, however systems were either not in place or robust enough to ensure the safe delivery of care. This placed people at risk of harm. This was a continued breach

of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 understood their responsibility under the duty of candour. Notifications were sent to CQC as required and the ratings from the last inspection were displayed.

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

At our last inspection the provider had failed to ensure people were supported to follow their interests and take part in activities which were socially and culturally meaningful to them. This was a breach of regulation 9 (Person-centred care) 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 9.

• There were no activities taking place and some people told us they were bored. People sat all day in chairs around the lounge areas and televisions played at each end of the room. People were not consulted about what they would like to do or to watch on television.
• There were no activity staff available to engage people in meaningful occupation or conversation and there was no management oversight of this.

We found no evidence that people had been harmed, however systems were either not in place or robust enough to ensure people were occupied in meaningful ways. This placed people at risk of harm. This was a continued breach of Regulation 9 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• A booking system was in place to manage visits to people from their relatives and friends. One relative told us, "It's never a problem to make an appointment to visit." Another relative said, "There are no time limits for visits."
• Relatives felt involved and informed about matters affecting their loved ones and they told us the management and staff were approachable if they had any concerns. One person said, "[Registered manager] speaks to you, asks you how you are and if there are any problems." Relatives said although there was no structure for formal feedback, they were always asked if they were happy with the care. One relative told us, "Apart from the laundry, everything goes like clockwork."
• The registered manager was considering ways to empower staff further and encourage them to be involved in the running of the service, for example through taking responsibility for specific areas of work.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others
• Staff spoke positively about the support they received from the registered manager.
• The registered manager acknowledged the areas of concerns and expressed commitment to making the necessary improvements identified by CQC and the local authority. However, actions from the expressed intentions were not always evident and concerns continued to be raised following the inspection.
• The home had extensive input from the local authority partners to help them to identify and begin to address improvements to the service.

Following the inspection, the registered manager communicated to us the improvements they had made in response to the issues found at inspection. These included amendments to care plans and engagement in some of the training offered by the local authority.